Final Report

Select Committee on

Adolescents in Need of Long Term Placement

Washington State
Department of Social
& Health Services

Children's Administration

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CONTENTS

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EXECUTIVE SUMMARY

Among the many children needing services and support from the Department of Social and Health Services (DSHS) is a group often referred to as "multi-needs" or "deep end" youth. These young people face many challenges: significant emotional and behavioral problems, mental illness, developmental disabilities, serious medical needs, substance abuse problems or a combination of several of these factors. In some instances they come from family environments of abuse and neglect. Their needs and behaviors make it difficult for parents or caregivers to care for them without a great deal of outside support.

For example, Teresa (not her real name) is a fifteen year old girl from southwestern Washington whose file is filled with diagnoses of ADHD, Conduct Disorder, Bi-Polar Disorder with Psychotic features, PTSD, manipulative, paranoid, schizophrenia, suicidal ideation, auditory and visual hallucinations, insomnia and hearing impairment.

She is physically and verbally assaultive, sets fires, threatens homicide, destroys property, is promiscuous, and can not control her anger. She has experimented with alcohol and crack cocaine and was involved with gangs. At school she allegedly bit the assistant principal and smeared feces.

Or Fred (not his real name), a nine year old boy from Pierce County, whose case file contains diagnoses of Axis I- Oppositional Defiant Disorder, PTSD, Reactive Attachment Disorder, Personality Change due to brain tumor and surgery, Axis III- Frontal Lobe Tumor, prenatal alcohol exposure, Axis IV- Psychosocial stressors-severe, Axis V GAF 45.

Fred was subjected to severe abuse and neglect during his first three years of life. When he came to the attention of CPS, he was described as "feral". He was a highly agitated child who engaged in assaultive behavior, such as attacking the teachers and other children in his therapeutic child care program. He was often observed chewing his clothing to pieces when agitated. He attempted to remove his clothes at any time or place for no apparent reason. He urinated and defecated wherever he felt like it. He made inappropriate sexual advances toward women, including his foster mother and his therapist, and younger children.

There are many children in Washington state with severe emotional and behavioral disorders. Many of their families are able, with a huge investment of support, energy and love, to access needed services and provide care for them. But, at any given time, there are also 30 – 50 children who, like Fred and Teresa, have significant challenges but whose biological parents are unable to care for them. Some parents don't know where to turn for help. Some become exhausted by the seven day a week, 24 hour a day needs of their child and are unable to get respite care to help them when things get overwhelming. Others ask for help and find systems too fragmented and inaccessible or are told that they are the problem

and the child needs to be 'placed' somewhere else. Other families have issues of drug or sexual abuse or lack the necessary parenting skills.

While there is a continuum of therapeutic and clinical services for seriously emotionally or behaviorally disturbed children and youth, ranging from residential treatment to enhanced foster care, as well as an array of programs aimed at maintaining healthy family functioning, the existing options are not meeting the needs of a group of 'hard to place' youth.

For these youth, DSHS spends an average of $75,000 per year on specialized foster care, group residential care or psychiatric hospitalization, along with a multitude of services.

In February of 2002, DSHS Secretary Braddock asked providers, judges and others with a wide range of expertise to come together as a group to assess how the Department could do a better job in serving these youth and their families. Are there internal changes he could make in the agency that would make a difference? Are there federal or state policies that create barriers to more thoughtful and fiscally prudent approaches? What enables some children to be served in family settings even though their problems are as severe as or more severe than these 30-50 children who have no place to go?

The group, called "The Select Committee on Adolescents in Need of Long Term Placement", held a series of meetings to hear from parents, youth, attorneys, case workers, providers and others. Some described the weaknesses and difficulties in how services for multi-needs youth and families have been traditionally provided. Others described promising new approaches showing improvements in behavior and family stability. Then, to get even broader input, more than 150 individuals statewide and across the country were interviewed. The input gathered, and the recommendations which flow from it, are described in Section V. of this report.

Some of the most important findings are:

- Put emphasis on preventing child/family problems from escalating by early screening and assessment of child and family needs at the earliest points of interaction between the family and the Department. Then provide integrated services and support specifically designed for multiple needs

- A differential response is needed for those families asking for help in dealing with their child's needs or family dysfunction than for those families where abuse, neglect or abandonment is the reason for DSHS' intervention.

- Improvements made in how services are provided should not be focused solely on this population. System-wide improvements in out-of-home care will help keep children from becoming 'hard to place.' Sufficient and accessible respite care is a good example. Requiring providers to have '24-7' crisis response capability is another. Conducting immediate and thorough searches for extended family members is a third.

- As has happened in some regions of the state, DSHS and others serving this population must shift from viewing parents of these youth as adversaries who are the cause of their child's difficulties to seeing them as valuable partners in decision-making and treatment. Similarly, staff need to see that extended family members are often willing to serve as caregivers, that parents who were unable to parent in the past can be capable parents at a later point in time and that older adolescents do want and need permanent, adult relationships. All of these permanency strategies are showing positive outcomes where they are being used.

- Community-based interventions have been traditionally dismissed as inappropriate on the assumption that these youth present too high a risk to self, family safety and community. But now research-based outcomes show three types of approaches are particularly effective interventions for youth with severe emotional and behavioral disorders. They have resulted in more children being able to stay with their families and less use of expensive alternatives such as group care and hospitalization. They are: Wraparound[1]; Treatment Foster Care and Multisystemic Therapy.

- Services and supports for complex needs should be delivered in home or community settings rather than in restrictive placements whenever possible. The services should be moved to the youth, rather than the youth having to be moved to get services. This strategy preserves the youth's ties to family, school and community and allows families to be partners in planning and treatment. It also ends the practice of requiring multiple failed placements in less restrictive placements before being able to receive services commensurate with complex needs. It minimizes the isolation of youth from their families and the use of settings dominated by peers, both of which

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[1] Many providers and agencies describe what they do as "wraparound", but they lack core elements that researchers indicate lead to positive outcomes. Burns and Goldman (1999) cite ten essential elements that define wraparound:

1. Services must be community-based.
2. Services must be individualized; strength based and designed to meet the needs of children to promote success, safety and permanence in home, school and community.
3. The process must be culturally competent.
4. Families must be full and active partners in every aspect of the process.
5. The approach must be team-driven, involving the child, family, natural supports, agencies and the community services working together to develop, implement and evaluate the individualized plan.
6. The teams must have adequate, flexible approaches and flexible funding.
7. Individualized plans must include formal services and informal resources.
8. An unconditional commitment to serve children and families is essential.
9. The process should be interagency, community-based and collaborative.
10. Outcomes must be determined and measured for the child/family, the program and the system.

have been shown to worsen behavioral difficulties rather than improve them.

- There are collaborative community-based efforts using these kind of approaches in some regions of the state that need to be sustained by articulation and actions of support from DSHS, including a shared commitment to serve every child, authority of those at the table representing DSHS to be full partners and funding, and policy decisions that provide the right incentives.

- Looking at a sample of these youth, a large proportion has mental health needs and anger control problems. The mental health system primarily serves them in one of two ways: crisis response when episodes requiring hospitalization occur, or 50 minute office visits to clinicians where the child is not viewed in the context of his/her family, school or peers. A significant shift in the way mental health services are provided needs to be undertaken, so that the primary interventions are preventative and sustained; are integrated with other services and supports being provided; are based in the community; utilize cognitive behavioral treatment; play a role in assisting the child welfare system in connecting youth with family or other permanent relationships; and achieve positive outcomes of healthier children and families.

- Youth with complex needs often bounce from system to system, getting sequential services and multiple case managers. If the initial assessment indicates a youth and family with complex needs and/or multiple system involvement, they should be able to be on a "complex needs track" with a single case manager and services provided in an integrated way.

- Frequently, expensive 'crisis placement' is needed due to a lack of transition planning. The Department often has to pay a much higher cost due to the emergency nature of the request, even though the transition was predictable. For example, a youth is released from a juvenile correctional facility or is stabilized after staying at a residential care or psychiatric facility. Some of these crises could be avoided by changing the practice of 'putting aside the file' once a youth is in an institutional setting and instead using the opportunity for outreach to family members for permanency planning. Emergency placement costs could also be avoided by creating an ability to hold beds for a period of time.

- Internal systems improvements that can have a positive impact include: improved cross-system collaboration and partnerships across the management of DSHS administrations and between DSHS and providers; information systems that provide information centered on the family or youth, in addition to the service or division; and performance-based

contracting that provides incentives for permanency, for individualized and tailored care and for improved outcomes.

- Liability laws and difficulty in siting housing and services in local communities are two barriers outside the control of DSHS that significantly affect how services are provided to this population (and many others). Overcoming these barriers is dependent on the actions of legislators, local governments and communities.

In the report that follows, we hope to shed light on who these youth are, what makes them 'hard to place' and what policy, practice and structural changes can be made to improve how they and their families are served.

I. INTRODUCTION

THE CHARGE

In February 2002, Department of Social and Health Services ("DSHS") Secretary Dennis Braddock asked judges, foster care providers, court commissioners, county prosecutors, group home providers, sheriffs, sex offender treatment professionals, high level DSHS administrators and others involved in serving children and families to come together as a group for a very specific task: help DSHS figure out how to better serve some of our state's most complex needs youth. In particular, Secretary Braddock was concerned about the number of adolescents who are in the care of DSHS for whom it has been difficult and costly to find long-term, stable homes.

The group, known as The Select Committee on Adolescents in Need of Long Term Placement ("the Committee"), was asked to examine the continuum of care and the sufficiency of services and housing options for these 'hard to place' youth.

Due to significant emotional and behavioral problems, sometimes combined with family dysfunction, the youth DSHS terms 'hard to place' are not living permanently with their biological families. Some repeatedly failed in foster care homes, others ended up in juvenile detention facilities. Some are admitted to residential group care, to crisis residential centers or psychiatric hospitals. Still others have a pattern of running from any setting, choosing instead to live on the streets. Lacking long range solutions, DSHS often spends significant amounts of money and time trying to find "emergency placements" for these youth, sometimes moving them on a daily basis - days spent in DSHS offices and nights in homes that take them only for a single night. In some cases, particularly for youth who commit sexual offenses, DSHS staff believe their only immediate option is to send them out of state because, in the view of many, these youth are a high risk to themselves and to the community, with no where else to go.

The charge from the Secretary to the Committee was to:

- Identify DSHS internal policies, practices, funding mechanisms and systems that are obstacles to integration of services in the continuum of care/treatment and transition of adolescents from custodial to community settings;
- Review state policy, laws, regulations and judicial decisions relating to treatment and placement of adolescents;
- Identify the "best practices" in the field by examining strategies utilized in other states;
- Use a "case study" to assess current DSHS procedures;

- Seek input from providers, parents, policy-makers, administrators and others involved in the issue of adolescents in need of long term placement;
- Review prior evaluations conducted and recommendations made; and
- Make recommendations for improvement, both internal and external to DSHS that may encompass organizational, policy, legal, systemic, community, financial or interagency solutions.

THE COMMITTEE

The Committee was chaired by State Supreme Court Justice Bobbe Bridge, a long time advocate for children and youth with a great deal of both judicial and community experience around these very issues. Anne Levinson, formerly the Presiding Judge of Seattle's Mental Health Court, was asked to serve as Special Counsel to the Committee. The Committee members represented a wide cross section of those involved in serving youth, with a wealth of experience and a diversity of perspectives. They were:

Bobbi Bowers
Washington State Certified Sex Offender Treatment Provider with 18 years of experience in juvenile justice. She serves as a contract therapist for Benton-Franklin Counties' Juvenile Justice Center Sex Offender Treatment Program.

Karl R. Brimner
Director, DSHS Mental Health Division. He previously served as the Northern Regional Coordinator for the Alaska Youth Initiative. He is also a licensed marriage and family therapist in the state of Alaska.

Judge Patricia Clark
King County Superior Court Judge currently assigned to the Unified Family Court. She previously chaired the Superior Court Judges Association's Family Juvenile Law Committee. In November, she will become the Juvenile Court Chief Judge for King County.

Fabienne Brooks
Chief, Criminal Investigations Division for the King County Sheriff, representing WASPC (Washington Association of Sheriffs and Police Chiefs) on the Select Committee. She is also a member of the King County Juvenile Justice Operational Master Plan Committee (JJOMP).

Susan Craighead
Commissioner, Court of Appeals, which includes responsibility for review of dependency and termination appeals. She previously served as a public defender for seven years, frequently representing very troubled youth.

anita delight (sic)
DSHS Division of Developmental Disabilities regional administrator in Region 5 (Pierce and Kitsap Counties). She began her career in secondary education. For the past 26 years she has worked in DSHS; 23 of those years have been with DDD.

Robert Faltermeyer
Executive Director, Excelsior Youth Center, a multi-service agency for families, for 20 years. He has also held leadership positions in national, state and local organizations promoting quality delivery of services to children and families.

Bob Jones
Director of the King County Blended Funding Project which blends funds from Education, Mental Health and Child Welfare to improve services and outcomes for difficult children. He previously served in the King County Mental Health Division as a planner implementing the Children's Mental Health Plan and EPSDT, and for 20 years in Residential Treatment for emotionally disturbed children as a therapist and program director.

Tom McBride
Executive Secretary, Washington Association of Prosecuting Attorneys since 1994. Previously, he served as a Deputy Prosecutor in King County, specializing in child abuse prosecution.

Royce Moe
Court Commissioner, Spokane County Superior Court. He was previously in private practice for 13 years. As a Court Commissioner for the last 14 years, he has worked extensively with youth and dependent families and has conducted involuntary civil commitment hearings for adults and juveniles.

Rosie Oreskovich
Assistant Secretary for DSHS' Children's Administration since 1994. She has more than 25 years experience in the field of child welfare.

Sharon Osborne
President & CEO, Children's Home Society of Washington, the oldest statewide children's service and advocacy organization, annually serving 30,000 children and their families. She also volunteers and consults with the Child Welfare League of America, Washington State's Children's Alliance, and is chair of the Board of Trustees for the Council on Accreditation for Children and Family Services.

Thomas E. Rembiesa
Chief Executive Officer for Ruth Dykeman Children's Center, with 29 years experience in social services. He has held leadership positions on Boards of Directors of Washington State and National Child Welfare advocacy organizations and currently serves on the Child Welfare League of America (CWLA) Advisory

Committee on Residential Care as well as the CWLA National Task Force to Revise Standards of Excellence for Residential Group Care.

Bob Russell
Social and health services manager for the Kalispel Tribe, working on helping Tribal members achieve improved health and social conditions consistent with their personal goals.

Cheryl Stephani
Assistant Secretary for DSHS' Juvenile Rehabilitation Administration. Previously, she served as the special assistant to the DSHS Secretary for over six years specializing in children's issues and organizational management.

Mary Stone-Smith, MA
System Director for Integrated Family Services of Catholic Community Services Western Washington. She has spent over 20 years in the field, working to create innovative services resulting in lifelong connections to family for children who are in need of permanency.

Jim Theofelis
Executive Director, The Mockingbird Society

Jean Wessman
Policy Director for Human Services, Juvenile Justice, and Housing for the Washington State Association of Counties. She has worked for the Association for 11 years, covering public health and health care issues as well. Previously, she served as nonpartisan staff to the Washington State House Human Services Committee where she was lead house policy staff on such issues as mental health reform, the Family Independence Program (FIP), the Alcohol, Drug Abuse Treatment and Support Act (ADATSA) and other health and human services issues.

Dr. Anne Nicoll, former Director of the Evaluation Center within the Northwest Institute for Children and Families at the University of Washington, was retained to help design and conduct out of state "best practices" interviews.

THE PROCESS

The Committee met five times throughout the spring and fall of 2002. An additional session was held in September to hear specifically about promising new programs. At its initial meeting, the Committee heard presentations from each of the senior DSHS administrators. Presenters were asked to highlight for the Committee their views of the most significant internal and external challenges that their administrations face in serving this population. For the Committee's second meeting, a team of senior Assistant Attorneys General ("AAG's"), whose practice centers on this population, presented an analysis of the external constraints and

factors which in their view influence DSHS' ability to provide services and housing. This covered everything from federal funding waivers to local community siting policies to liability risks for providers, parents and DSHS.

The third meeting included two panels and a review of cases studies. The panels were comprised of foster and biological parents, a foster child, social workers, treatment providers and DSHS managers. Each was given a chance to share with the Committee his or her perspective about how the system works, or doesn't, and what they would like to see changed. The case studies included four portrayals of some of the most complex and difficult youth for whom DSHS staff were at that very time trying to find services and housing. The case studies were written and presented by the staff from across the state who were responsible for helping these particular youth. The Committee discussed with the staff what outcomes they were striving for and what the factors were which made these youth so difficult to successfully serve.

To get additional public input, the Committee created a website, FosterCareIdeas@DSHS.wa.gov so that any person interested in sharing his or her experiences, perspectives or recommendations with the Committee could easily do so. Committee staff reviewed all email correspondence and included that input as part of the research and interview follow up.

Over the course of the summer, more than 150 key informants from across the state and throughout the country were interviewed. The interviewees included foster and biological parents, youth, group care providers, foster care providers, case managers, psychiatric professionals, sex offender treatment providers, juvenile justice administrators, juvenile correctional administrators, researchers, victim advocates, professional associations, legislators, judges, commissioners, DSHS regional administrators and managers, parent advocates, regional support network ("RSN") staff, treatment providers, social workers, Children's Long-Term Inpatient Program ("CLIP") staff and those creating or administering promising programs in other states.

Committee staff also reviewed judicial decisions, previous and current task forces' reports, program summaries, budgets, research literature, statutes, federal regulations and news clippings.

The Committee received material and heard presentations about promising programs and new approaches with proven outcomes. The Committee then reviewed all of the input it had received and spent its last two meetings discussing issues and formulating recommendations. All meetings were open to the public, with parents, advocates and legislators often attending.

II. DEFINING THE PROBLEM

In order to help DSHS design strategies for better serving 'hard to place' youth, the Committee's first task was to learn more about who comprises this population. What makes a youth "hard to place"? Are there common family histories, behavior patterns or diagnoses? Are they only from some DSHS service areas ("regions") or all of them? Are they disproportionally from a particular ethnic or racial background, gender or age group? Are there dozens or hundreds needing DSHS' help on any given day? How much is DSHS spending on a monthly or yearly basis to provide them services now?

THE POPULATION

Often referred to as "multi-needs", "multi-system", "deep end" or "high risk to fail" kids, we know that youth in this group have significant behavioral problems, mental illness, developmental disability, substance abuse or a combination of several of these elements. They typically begin life with multiple risk factors, and depending on whether appropriate intervention occurs, have increasingly severe emotional and behavioral problems that become very obvious by adolescence. They have by then had problems in school, at home and in the community. They are doing less well than their peers with regard to intellectual and educational performance and social or adaptive behaviors. They may be defiant, displaying bursts of anger, and engaging in conduct disorders that repeatedly get them into trouble. They come from all regions of the state.

Case workers, parents and service providers were asked by the Committee to describe common characteristics of these youth. Based on that input, the Committee developed the following definition of 'hard to place' youth:

Youth with co-occurring issues of (demonstrating acuity in one or more areas):

- mental illness
- substance abuse
- repeating pattern of property destruction
- assaultive behavior
- sexually offending behavior
- fire-setting behavior
- and/or significant cognitive impairments (up to age 21 if under the jurisdiction of JRA)

And with one or more of the following characteristics:

- "burned out" multiple placement resources
- danger to themselves or others
- danger to the community

- history of running from placements, even staff-secure facilities
- behaviors or conditions that make it particularly challenging to reduce or stabilize needs in the foreseeable future
- media exposure that raises community concern

Sample case file snapshots underscore the difficult family situations and multiple, serious needs these youth face:

A 15 year old Caucasian female from southwestern Washington, first placed at age 12:

Diagnoses/Issues: ADHD, Conduct Disorder, Bi-Polar Disorder with Psychotic features, PTSD, manipulative, paranoid, schizophrenia, physical and verbal aggression, suicidal ideation, fire setting, attention-seeking behaviors, criminal behavior (assault, threats of homicide, property destruction), promiscuity, insomnia, anger management. Auditory and visual hallucinations. Hearing impaired. Experimentation with alcohol and crack cocaine. Gang involved. Previous behaviors at school have included biting the assistant principal and smearing feces.

Family History: Child was living with mother and stepfather prior to current placement. They are involved and in frequent contact. However, the family does not feel safe to have child at home, due to physical assaults on both parents and siblings. Also prior to this placement, child was sent to her father's home in N. Carolina, but was hospitalized for 8 of the 12 months she was there.

A 13 year old African American youth from King County, first placed at age eight:

Diagnoses/Issues: Fire-setting, physical aggression, runaway behavior, cruelty to animals, Depression, ADHD, stealing, destructive behavior, sleep disturbance, possible PTSD, ODD

Education Information: IQ 97. Special Ed eligibility determined in middle school – class changes and the looser environment prevented this child from functioning in the regular school environment. Runs away from school and behaves in ways to distract others from their work, resulting in numerous suspensions. Problems with rules and directions in all environments.

Family Background: This child has been dependent since 1990, but was place with relatives until 1997. He reported that his grandmother would beat him and not feed him. An aunt agreed to take over the guardianship, but a few months later, in Feb 1998, the aunt brought him to the DCFS office, saying she could no longer care for him. This disruption was hard on him and he blew through 3 placements in 2 months before settling into a foster home

where he stayed for 2 years. However, the children were removed from that home in May 2000, as the 81 year old foster mother was no longer able to provide the level of care they needed. The aunt was again considered as a placement, but after a period of visitation, the aunt declined to be a placement resource, but has continued to see him regularly. Mother's parental rights were terminated in 1995 and the father is deceased.

This child was removed from his mother's care as an infant due to parental substance abuse and injuries suffered as a result of physical abuse. He was in guardianship with relatives until allegations of abuse by the grandmother. After a period with several placements due to his disruptive behavior, he had a placement of 2 years, and then another placement that lasted a year. This family expressed an interest in being a long term resource for him, but wanted more money than the department could authorize.

A nine year old Caucasian youth from Pierce County, whose first placement was at age three:

Diagnoses/Issues: Axis I- Oppositional Defiant Disorder, PTSD, Reactive Attachment Disorder, Personality Change due to Brain Tumor and Surgery, Axis II- none, Axis III- Frontal Lobe Tumor, prenatal alcohol exposure, Axis IV- Psychosocial stressors severe, Axis V GAF 45

Family Background: This child was subjected to severe abuse and neglect during his first 3 years of life. When he first came to the attention of CPS in 1996 he was described as "feral". He was a highly agitated child with poor boundaries and very assaultive behavior. He was often observed chewing his clothing to pieces when agitated. His history is sketchy up to the point he was placed in foster care.

Following a series of 4 short-term receiving home placements between June and August 1996, he was placed in a foster home where he remained from 8/96 to 5/2000. During his placement in this home it was reported that his behavior was consistently disturbed. He unpredictably attacked the teachers and other children in his therapeutic child care program. He was unable to tolerate even minimal changes in his daily routine. Even changes in bus drivers evolved into violent outbursts and spitting, biting, and kicking. He attempted to remove his clothes at any time or place with no apparent reason. He urinated and defecated wherever he felt like it. He was not able to share the attention of his foster parents with other children and often told them that he hoped the baby in the home would die. He consistently demonstrated inappropriate sexual behavior with women, including his foster mother and his therapist, and with younger children.

During this placement he also demonstrated "different voices" and bouts of Dissociative Behavior. There has been debate between different mental health providers as to a diagnosis of Multiple Personality Disorder.

In 1996, he was diagnosed with an ependymoma brain tumor which was partially removed. He has been followed by Children's Hospital since the surgery and radiation. He suffers risk of seizures associated with the tumor.

The next step for the Committee was to try to ascertain how many of these 'hard to place' youth need help from the State each year. The answer is not as simple as it would appear.

First, a bright yellow line between these youth and other youth with complex needs does not exist. It can be a very fluid population. Emergent situations arise unexpectedly and sometimes can be solved in an equally unforeseen way. A relative may come forward and offer a long term solution without a great deal of difficulty. Conversely, another youth with similar needs may end up in the lobby of a DSHS office. His parent suddenly informs the State that the family will not take him back at the time of his release from a juvenile rehabilitation facility. Not previously on anyone's list as 'hard to place', he now becomes a dependent of the State with a criminal conviction on his record and no place to go.

Second, each division of DSHS uses a different information management system and defines its client populations differently. Since these youth utilize multiple services from DSHS, tracking them requires an integrated approach in information management that DSHS does not have.[2]

Finally, and most importantly, one would expect to see similar numbers of 'hard to place' youth in each region, but because some regions are using other approaches in working with biological and foster families, they are not 'placing' youth in multiple fosters homes, group care settings or out of state treatment centers. These regions of the state thus do not have 'hard to place' youth lacking places to live as a distinct group from the rest of their complex needs clients. (*See Section III. Promising Practices & Model Programs*)

Taking all these factors into account, interviewees, administrators and budget analysts estimate that at any given time, DSHS has the most difficulty finding any appropriate placement for approximately 30 - 50 children with severe emotional and behavioral needs.

To get a more complete picture of these youth, the child welfare, juvenile rehabilitation, developmental disabilities, and mental health programs each asked their field offices to send forward case information on the young people who had

[2] Because of the expense of creating such a system on an agency-wide basis, only one state - Delaware - has a management information system that integrates all of its client information.

been most difficult to place or were most expensive during the past year. The regions were asked to summarize background information from both the automated systems and the paper files; it was then consolidated into a single data base.

Looking at this sample, the 'hard to place' youth tend to fall into three different categories:

1. A few youth whose major care problem is their intense medical care needs and conditions, complicated by some behavioral issues.

2. Older adolescents with behavior and mental health needs (and in some cases developmental issues) who are aging out of the system and leaving JRA.[3]

3. Youth with intense behavioral and mental health issues.

More specifically, the 131 youth described by the staff as 'hard to place' have these characteristics, as described in case files by staff and professionals with whom they have interacted:

- **Four out of five are male.**
  - 28 (21%) are girls or young women
  - 103 (79%) are boys or young men
- **Four out of five are between fifteen and eighteen years of age.**

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[3] The Juvenile Rehabilitation Administration ("JRA") is responsible for the confinement and rehabilitation of juveniles 10 to 21 years of age who have committed multiple and/or serious crimes. These young people have been convicted of crimes in local juvenile courts and sentenced to specific terms of confinement with JRA. Currently, JRA offers rehabilitative treatment in five institutions providing medium and maximum security confinement, one basic training camp, and a number of small community residential facilities.

Approximately 61% of the youth sent to JRA have substance abuse problems. Approximately 50% of the JRA population needs mental health services. Of them, 81% have a DSM-IV Axis1 diagnosis (not including conduct disorder or oppositional defiant disorder), 46% are on psychotropic medications, 90% have 2 or more service needs, and 50% have 3 or more service needs. For youth leaving JRA facilities, approximately 40-60 are released per year who JRA describes as 'hard to place'. About 20 are Level II and III sex offenders. 92% male; 77% Caucasian; 41% with prior criminal history. The other 40 (non sex offender) youth who comprise the rest have demographics roughly proportional to that found in the system as a whole, approximately 44% youth of color -- about 19% African American; 5% Native American; 14% Hispanic; and 4% Asian Pacific Islander. 30% of the sex offender youth, 50% of the MH males and 30% of the MH girls exit JRA between the ages of 18 -21. (Source: JRA)

- 17 (13%) are under thirteen
- 25 (19%) are thirteen or fourteen
- 43 (33%) are fifteen or sixteen
- 38 (29%) are seventeen or eighteen
- 8 (6%) are nineteen or twenty

➢ **Two out of three are White and not Hispanic. African-Americans and American Indians are somewhat over-represented compared to their distribution in the general population.**

- 86 (66%) of these young people are White and not Hispanic
- 18 (14%) are African American and not Hispanic
- 13 (10%) are American Indian and not Hispanic
- 8 (6%) are Hispanic of all races
- 4 (3%) are of unknown or "other" race
- 2 (2%) are Asian

➢ **Per the case files, 125 (95%) have at least one mental health diagnosis or the statement that the youth has mental health needs.**
These youth on average have been diagnosed with three psychiatric diagnoses. Most common are:

- 71 (54%) with Attention Deficit Hyperactivity Disorder (ADHD) or ADD
- 52 (40%) with Oppositional Defiant Disorder
- 44 (34%) with Post Traumatic Stress Disorder
- 43 (33%) with Conduct Disorder
- 40 (31%) with Depression or Dysthemia
- 20 (15%) with Reactive Attachment Disorder or Attachment Issues
- 17 (13%) with Bipolar Disorder
- 14 (11%) with Borderline Personality
- 14 (11%) with Psychotic Disorders

- **The case files indicate that 13 (10%) also have birth parents with mental illnesses.**

- **Some have medical problems as well.**
  - 17 (13%) have seizure disorders, some very severe
  - 17 (13%) have brain damage or head injury
  - Small numbers have many other medical conditions that complicate their lives and those of their caregivers
  - Four are so medically fragile that they require round-the-clock nursing care

- **Three out of four (99 or 76%) of these youth have significant anger control problems. Many are habitually assaultive and aggressive.**

  "Foster parents initiated the process to adopt him. However, his continual threats to the baby in the home, his self-injurious behavior and rages changed their minds." (Brain damaged 9 year old boy)

  "The adoption disrupted...due to the child's extreme behavior and assaults on other children in the home." (10 year old; now a 15 year old boy)

- **One in five (26 or 20 %) repeatedly destroy property.**

- **One in six (21 or 16%) set fires.**

- **Over half (69 or 53%) are sexually aggressive.**

  Of these, (45 or 33%) are registered sex offenders or have been labeled as high risks to the community.

  "He is a high risk, requiring 24/7 eyes-on supervision and recommended that he be placed in a highly secured sex offender treatment facility. He is a danger to the community." (A psychologist's evaluation of a 17 year old youth who had been sexually abused by his father).

- **Over six out of ten of these young people (81 or 62%) have documented histories of abuse and neglect in their birth families.[4]**

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[4] The percentages described in this section related to birth families may be less than actual. By the time these youth are older adolescents, the files tend to be focused on treatment and placement information and not on less recent information about birth families.

"This child came to the attention of CPS at the age of two. He had been living with his mother and her several boyfriends in Oregon and then in two other states. She acknowledges that he was abused by many of these men … When first placed he was battered and bruised, malnourished and uncommunicative." (now 11)

"Child was voluntarily placed by the mother with his maternal aunt after he disclosed his mother was sexually abusing him. He also later disclosed sexual abuse by the grandfather, who is in prison for life." (now 16 and a sexually aggressive youth)

- **The case files show that one in three of these children (49 or 37%) had a substance-abusing parent.**

- **More than one in four of these youth were exposed to alcohol and/or other drugs prenatally.**

  34 (26%) of the young people in the sample were either diagnosed with fetal alcohol syndrome (FAS) or Alcohol-Related Neurodevelopmental Disorder (ARND), or were known to have other prenatal drug exposures.

- **Not surprisingly, almost one in five (24 or 18%) have substance abuse problems themselves.**
- **Over one in three (48 or 37%) have had suicidal ideas or behavior, or repeatedly harmed themselves.**

  "He has asked his foster father to stab him and at times is so desperate that he states simply that he wants to die". (9 year old boy)

  "His most common form of self-mutilation is to gnaw bite size chunks out of his hands and forearms … he will use … shards [of glass] to cut himself and threaten others." (16 year old boy)

- **Over half (73 or 56%) have learning disorders, developmental delays or cognitive impairments.**

  - 46 (35%) are mentally retarded
  - 7 (5%) have very limited verbal communication abilities
  - For 7 (5%), the birth parents were recorded in the case files as having cognitive problems as well

SERVICE ACROSS DSHS

We know that children and adolescents with the most severe disorders usually have needs that require services from at least two child serving systems, along with medical care and other support. They have a history of getting bounced from one service system to another, including child welfare, mental health, juvenile justice, substance abuse, developmental disability and special education.

The database was matched with the DSHS Client Registry, to gain a clearer picture of how these young people have been served across the department. The Client Registry is a cross-DSHS database that has complete data across DSHS since 1997, and partial data for several years further back. It is not a case management system. Instead it is designed to help case managers form teams by letting them know who across the department is also serving or has recently served their client. Hence it contains only a little information – which programs have served a particular client during which months.

As the table below shows, most youth in this group are served by two, three or all four programs. Just five were served by only one of the four child-serving programs during the past five years.

DSHS Program	Number[5]	Percent
Mental Health, Children's	49	38%
Mental Health, Children's, Juvenile Rehabilitation	33	25%
Mental Health, Children's, Developmental Disabilities	18	14%
Mental Health, Children's, Developmental Disabilities, Juvenile Rehabilitation	8	6%
Mental Health, Juvenile Rehabilitation	7	5%
Children's, Developmental Disabilities	4	3%
Children's, Juvenile Rehabilitation	4	3%
Children's	3	2%
Children's, Developmental Disabilities, Juvenile Rehabilitation	1	1%
Mental Health, Developmental Disabilities	1	1%
Juvenile Rehabilitation	1	1%
Developmental Disabilities	1	1%

THE COST

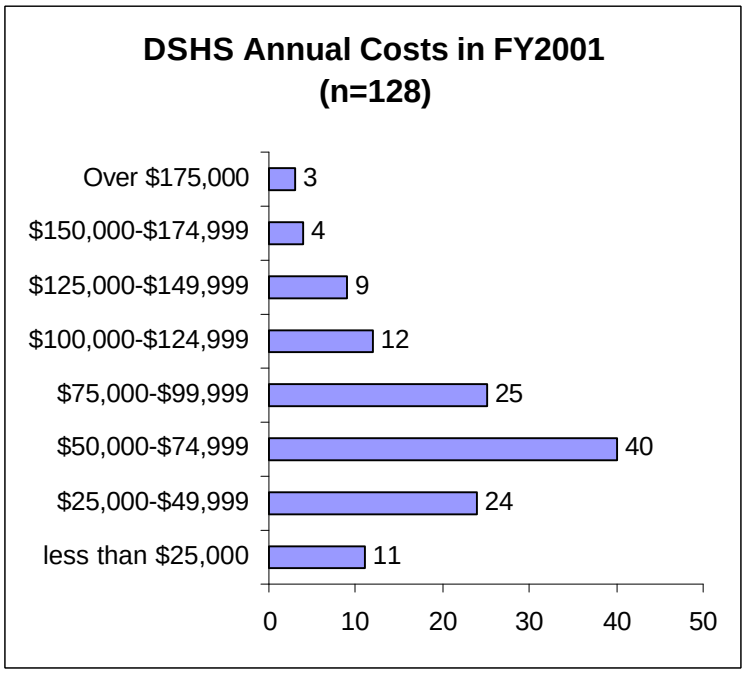
The Committee also wanted to learn how much money on average is spent by DSHS on these complex needs youth, as a way to assess whether other service approaches would be more expensive, less expensive or comparable in cost.

[5] Note: One client could not be matched in Client Registry, so the n for this table is 130 youth.

Information was gathered across all DSHS programs who served the youth in 2001.[6]

- The average annual cost was $75,201.
- The lowest cost was $3,302 in adoption support costs for a child whose case resolved in FY2001.
- The highest cost was $319,746 for a youth who was in and out of a psychiatric hospital, JRA institution, DDD institutions and who was receiving wraparound services and intense supervision in a community placement.

The table below shows the range of fiscal year 2001 costs:



PLACEMENT OPTIONS

When parents are struggling with behavioral and emotional challenges of their children, or when there are issues of abuse, neglect or abandonment[7], there are a

6 Note: Only 128 of these youth could be matched across all data systems, so the n for this table is 128 youth.

variety of family and institutional settings the State turns to for care. Depending on the nature of the issues and the family environment, a youth can remain with his or her biological family, with support and connections offered through family reconciliation services to such programs as homebuilders. The other family-like settings are placement with relatives or tribe (called kinship care), with unrelated family (foster care) or foster care with additional services for more complex needs (called therapeutic or treatment foster care).

The non-family-like or more institutional options such as residential group care[8] (both in-state and out-of-state) or psychiatric in-patient beds are to be primarily used to help stabilize a youth and provide intensive treatment, rather than as placement options. However, historically they have been the primary placement options when intensive treatment was needed and to some extent continue to be used for placement in Washington state.[9]

Nationally, however, over the last decade the trend has been that more and more youth with severe emotional and behavioral needs have been served in their communities with a variety of approaches; that is, services are being brought to the youth and family, rather than the youth having to leave the community and be "placed" in order to receive those services. (*See Section III. Promising Practices & Model Programs*)

It is traditional practice, and legally mandated, that children should be placed in the least restrictive (most family-like) setting possible.[10] It is expected that less

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[7] In 2000, 61% of children were removed from their homes as a result of abuse or neglect. 18% enter care due to family conflict. 21% are placed out of the home because a parent requests help dealing with significant behavioral problems, mental illness, developmental disability or substance abuse. *Doran and Berliner, Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review-(Olympia, WA: Washington State Institute for Public Policy, February 2001), Document Number 01-02-3902.*

[8] Residential group care is often used for children with significant emotional or behavioral problems who require more restrictive environments or 24 hour a day care. Group care can range from large institutional environments to smaller residential treatment centers to small home environments which incorporate a "house parent" model. They can provide various levels of structure, programs tailored to individual, group and family therapy, supervision and services targeted to a specific population of children or a range of services depending on the design of their program. Some are located in community settings where families are able to participate in treatment, youth are able to attend local schools and participate in community activities.

[9] Where families are not immediately able to care for complex needs youth who are placed in residential care for acute and intensive treatment, residential care continues to be viewed by some as a long-term placement option rather than a treatment option in a continuum of care.

[10] The Adoption Assistance and Child Welfare Act of 1980 made placement prevention and permanency planning explicit objectives of federal child welfare policy and required states to establish standards and procedures consistent with the law. The Law requires that out-of-home placements be arranged in the *least restrictive, most family-like setting* available located in *close proximity* to the parents' home, consistent with the *best interests and needs of the child*, and that children be discharged to *permanent homes* in a timely manner. In Washington, The Act is codified

restrictive placements are ruled out before progressing to more restrictive options (group care or hospitalization) *CA 2000a*. The more restrictive the setting, the higher the cost to the State.[11]

MULTIPLE PLACEMENTS

Per both State and Federal law, the preferred goal for, and the right of, each youth is to a permanent, stable and secure place to be.

We know that behavior problems can create difficulties in a child's placement and ultimately lead to multiple placements, which in turn are associated with worse outcomes for children. And the research tells us that even for children who have less significant behavioral problems, being moved from setting to setting often increases their problems. The presence of behavioral problems is a major risk factor for foster family breakdown and placement instability. (*Scholte, 1997; Nugent and Glisson, 1999; Newton, Litrownik and Landsverk, 1999*)

In Washington state, school age children and emotionally disturbed children, in particular, are more likely to experience multiple placements. (*See Doran and Berliner, Placement Decisions for Children in Long-Term Foster Care: Innovative Practices and Literature Review: Washington State Institute for Public Policy, 2001*)

Given the harm associated with multiple placements, the numbers of children being moved multiple times are important to understand. But even that picture doesn't tell the whole story. The number of disruptions and detachments for 'hard to place' youth is often even greater than their number of "placements". If a youth is hospitalized, is sent to a juvenile detention facility or runs to the streets, these are not counted as additional "placements". But each also entails a transition.

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in RCW 74.13.065. This state statute requires a social study for any out-of-home placement and an assessment of the following:
Physical and emotional strengths and needs of the child;
Proximity of placement to the child's family to aid reunification;
Possibility of placement with relatives or extended family;
Racial, ethnic, cultural, and religious background of the child;
Least-restrictive, most family-like placement reasonably available and capable of meeting the child's needs; and
Compliance with RCW 13.34.260 regarding parental preferences for placement of their children.

[11] Though group homes are designed to be the placement of last resort, providers say even they are sometimes not equipped to care for the most difficult youth. DSHS does not have a "no refusal" policy with group care providers. If a provider believes the youth DSHS would like to place with them is not a good fit for their treatment setting, they may decline to accept that youth. Or, if they do accept him or her, the youth may later be kicked out for aggressive behavior, running away or using drugs. DSHS social workers are left to plead with foster parents or other group homes to take in that youth, because, while the State is required to find housing, nobody is required to take them. As a result, youth who act out may bounce between group homes and foster homes repeatedly.

And it is the transition periods that many experts say are the most critical to successful outcomes in the long run. It is often during these transition periods that the ‘placement crises’ occur, as case workers and managers scramble to find a place, any place, for a youth who has nowhere to go. With this ‘placement’ approach, the result may not be the most appropriate, the cost may be significant and the goal of permanency may be no closer to being achieved.

III. PROMISING PRACTICES & MODEL PROGRAMS

Around the country and in Washington state, there are a number of promising programs and evidence-based practices that are showing success with adolescents who fit the definition of 'hard to place'. To find that out more about these, a review of the literature was undertaken and researchers, educators, practitioners, consultants and advocates across the country were interviewed.

Included in this review were interviews conducted in several regions of Washington state that were identified as having made significant changes in philosophy and approach in order to better address the needs of this population. The Committee wanted to learn what makes those efforts successful, how they got started and whether they can be sustained, replicated or expanded.

This section summarizes the results of both the in state and out of state review of practices and programs.

PHILOSOPHY AND ASSUMPTIONS

Both practitioners and researchers articulate the position that policies and practices commonly used are based on long-standing assumptions about complex needs youth and their families that are incorrect. Interviewees stress that these assumptions or practice biases have led to an emphasis on the need for facilities or 'placements' rather than re-thinking the nature of services and how they are delivered. In their view, changed intervention approaches in various parts of the country, including Washington state, and research examining outcomes of these approaches, should lead our state to re-assess how it serves youth with complex needs.

Traditionally, community-based interventions have been dismissed as inappropriate on the theory that these youth present too high a risk to self, family safety and community. But to the contrary, wraparound services and multi-systemic treatment that involve the participation of the family, the youth, multiple health, educational, social service and other system partners are proving to be successful in improving the health and well being of youth with severe emotional and behavioral needs, reducing the need for hospitalization and other expensive 'crisis' placements.

These efforts are showing that very few youth have problems which are too complex for community-based programs and strategies. Instead of a practice model that focuses on 'placement', the focus in the 'best practices' models is on intervention at the appropriate time and with the appropriate tools, striving for healthy children, families and permanency.

Interviewees note that in Washington state, as in many other states, *placement* is the service model. With this approach, the State does not immediately step in with the intensity of services needed as early as possible, because more intense, multi-system services are only provided in more restrictive settings. Since federal and state laws require use of "least restrictive" settings, and since the needed services are only provided in more restrictive settings, the result is that the State uses a practice of multiple placements that must first fail before the youth is 'placed' in a setting where services are commensurate with the needs. As sequential steps are taken, youth languish. They go from system to system, become more dysfunctional, with multiple case managers and multiple unsuccessful placements. Thus, it is the nature of the system approach, not just the complexity of their needs, which puts these youth on a path of becoming 'hard to place'.

Those regions of the state using a placement model see youth in their office lobbies, spend large amounts of resources on a small number of kids and have to scramble over and over to find placement. They tend to have more of a "system barriers perspective". For them, the primary issue is that the continuum of care does not include sufficient facility-based options to meet the complexity of needs, the laws and funding streams are too constraining and the youth are often too dangerous for the types of placement options they have.

In contrast, those who utilize models where services are delivered in an integrated fashion in the home and community articulate more of an "approach to care perspective". They don't view youth as 'hard to place'. It is not facilities and laws they see as most important. What they believe would have the most impact is changing the nature of the actions taken at the time of initial intervention, assumptions about these youth and their families, values, policies, practices and outcome expectations by those who serve youth.

MOVING THE SERVICES INSTEAD OF MOVING THE YOUTH

In many parts of the country, the approach to serving children with severe emotional disorders, such as those who are the focus of the Committee's work, is undergoing a dramatic transition. What traditionally have been considered effective interventions have been shown to lack evidence of positive outcomes, leading to new understanding of what constitutes effective intervention and new models of how services are delivered. Over the last decade, there has been a dramatic shift from institutional to community-based interventions, with home-based services and therapeutic foster care showing the most convincing evidence of effectiveness for even the most complex needs youth.

In the past, preference for use of treatment facilities has been justified on the basis of community protection, child protection, and benefits of residential treatment per se. However, none of these justifications have stood up to research scrutiny. Controlled studies of institutional care – psychiatric hospitals, traditional residential treatment centers and detention centers- have not found

positive outcomes in such settings.[12] For example, inpatient care consumes half of child mental health resources, but it is the clinical intervention with the weakest research support. (*Surgeon General's Report on Children's Mental Health, 2000*)

The standard approach to serving youth with severe behavioral or emotional disorders has been to locate intensive services almost exclusively in either the office of a mental health professional or in a residential institution. But now there is a growing body of research that children with severe emotional and behavioral disorders can be effectively treated in their home communities. *(Duchnowski, Kutash & Friedman, 2002)*

Thus, a major characteristic of the emerging service delivery system that is taking shape in this country is the change in location of intensive treatment from office and institution to home and community settings.

With the practice model in Washington state traditionally being to remove children from their natural setting, ostensibly in an effort to safeguard the community and protect the child, placement decisions have been paramount. In the promising practice models, there is a commitment instead to serving youth in their natural setting. This means resources are brought to the youth rather than the youth being brought to the resources.

Researchers emphasize that the best outcomes come from interventions that locate intensive services and support in the home and the community, with the family as an integral partner in implementing the intervention. Where that is not possible and an out-of-home placement is seen as necessary, the treatment foster care model, based on the concept of the family unit as the primary caregiver, has demonstrated strong evidence of effectiveness. (*See below*) Both involve services delivered in an integrated fashion, not piecemeal, system by system.

Even in those instances where a decision is made to remove a youth from his or her home or community, research is driving changes in how that intervention should occur.[13] For example, researchers are clear that residential programs must

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12 There is initial positive evidence for dialectic behavior therapy models just beginning to be used by the Juvenile Rehabilitation Administration ("JRA"). These programs are tailored for use in settings in the juvenile justice continuum of care. *See "Preliminary Findings for the JRA's Dialectic Behavior Therapy Program", Washington State Institute for Public Policy, July 2002*

13 In 1999, the Juvenile Rehabilitation implemented a research-based treatment model that utilized cognitive-behavioral principles. The model was to be tailored for use in both residential and community settings in the juvenile justice continuum of care. Goals for the model included: research-based effectiveness, motivation and engagement of both youth and families, a commonly understood language to be utilized throughout the juvenile justice continuum, a uniform set of cognitive-behavioral skills, the ability to generalize and maintain positive changes, and ongoing clinical consultation system to ensure the continuity of the interventions and adherence to the model.

be designed to involve the family and include the provision of aftercare services during the youth's transition and stabilization back into his or her family. Programs that do not include these critical components are unable to demonstrate improved outcomes. Youth often return to their former behavior patterns, failing to generalize changes accomplished during structured treatment.

However, when family and community partners are involved, and residential treatment is focused not on placement but on helping to stabilize a child's behavior, and there is continuity of caregivers and treatment professionals after the stabilization, there are likely to be more positive outcomes. Parental involvement and family support in the treatment process for youth removed from their homes are among the strongest predictors of a youth's ability to adapt successfully to the community upon his or her return. (*Jenson and Whittaker, Parental Involvement in Children's Residential Treatment, 1987)*

The overarching theme of new practice models is "unconditional care", or put another way, we will do whatever it takes to serve any child from our community in our community. Interviewees suggest shifting from a perspective where the State identifies "kinds of kids" to one that understands youth, individually, in the context of their community and the community's response to them. A key part of this is to eliminate the approach of defining populations based on services needed and then "sending kids" to these services, with needs often diagnosed based on available resources. Interviewees repeatedly make the case that these youth do not have to be 'sent off to get better'.

The evidence is growing that isolation of adolescents in specialty programs outside of their normative family and community can cause an exacerbation of the very problems that treatment is intended to ameliorate. (*English, 2002; Barker, 1998*) As one interviewee stated, "It is disheartening that the usual pattern of response is that the more difficult a child's needs are perceived to be, the more we isolate him or her from any family or community."

In residential care, (state institutions and community facilities) the model focuses on improving the skills of the youth who is separated from his/her family and removed from the community context in which his behavior occurred.

Once a youth leaves residential care and moves back into the community, the context in which his/her behavior is viewed changes. In community settings, where youth are monitored while on parole, the primary focus shifts to creating a more functional environment within the family where the youth resides. Again, research on maintaining and supporting behavior change for troubled adolescents indicates intervention is most effective if supported within a family context. Parole staff will work with families to shift the "problem behavior" to a relational issue between family members. The primary theoretical underpinnings for this section of the model come from James Alexander, Ph.D and Thomas Sexton, Ph.D., in Functional Family Therapy, a research-based family intervention considered to be a "Blueprint" effectiveness model from the Center for the Study and Prevention of Violence.

CHANGING THE ROLE OF THE FAMILY

A second important characteristic of the shift in interventions for youth with significant emotional or behavioral needs like those of 'hard to place' youth, is the change in attitude toward the families, from that of a dysfunctional cause of the child's psychopathology to an effective partner with professionals. (*Duchnowski; Kutash; Friedman, 2002*)

Model programs acknowledge that all families have strengths and any intervention must build on these strengths, rather than devote time only to what troubles children, their families, and the communities in which they live. These programs also recognize that children do not exist in a separate microcosm; focusing on the child alone ignores an entire support system already in place. (*Levine, 1997*)

Interviewees emphasize the effectiveness of programs for complex needs youth that are aimed at strengthening the ability of families to raise children, using services which are more normative and tailored to their specific needs, done in a less structured and more informal manner which tends to more actively engage the youth and family members. Comprehensive and strength-based interventions attend to the entire range of developmental outcomes of the child (cognitive, behavioral, social, emotional, physical, and spiritual) through improvements in all environmental domains (society/culture, community, neighborhood, school, peer group, and family/extended family).

Family therapy interventions are used with families in which preteens or adolescents are already manifesting behavioral problems. Research has demonstrated that family therapy improves family communications, family control imbalances, and family relationships (*Substance Abuse and Mental Health Services Administration, 1998*).[14] Interviewees again spoke to these services being most effective when provided in an informal and unstructured manner – i.e. the family's living room – without the use of clinical "jargon" (i.e., referring to family meetings rather than "therapy").

Promising models are also showing the importance of reaching out to extended families and understanding that significant adults <u>will</u> step forward to take care of these youth if asked and involved.[15] Relatives do not write complex needs youth

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[14] Two family therapy programs in particular were cited as exemplary family programs because of their effectiveness in reducing delinquency and drug use in preteens and adolescents. Functional Family Therapy *(Alexander and Parsons,1982) and Multisystemic Therapy (Borduin et al., 1994; Henggeler,1997; Henggeler and Borduin,1990*). Both are currently used by JRA and some RSNs.

[15] Looking for extended family members seems like an obvious strategy to avoid keeping youth 'in the system' and experiencing multiple placements. Yet there is still a pervasive practice philosophy among those serving youth that if family is available, they would have come forward, so there is no point in searching. Interviewees mentioned several reasons why that is not often a correct assumption: children have been lost due to broken family connections, multiple

off as too difficult or too dangerous. Nor is it the case that youth don't have extended family to involve, it just takes a philosophy that it is important to find and involve them.[16]

Traditional practices of thinking that when youth turn 15 or 16 they no longer want or need permanent family connections are also being set aside. Programs working on finding connections for older youth are having good success achieving positive life, school and behavioral outcomes.[17] They focus permanency strategies for adolescents on connections more than places, and effectively make the case that older youth do want families, despite age, attachment difficulties and what they say they want. These programs have also reinforced the need to train case workers to quickly and systematically seek out relatives in every case, and to include them in the youth's life in whatever role they can play, rather than ignoring them if they are unable to be full-time care givers.

New service delivery models provide a great deal of evidence that families often thought of by case workers as too dysfunctional can and need to play a significant, positive role in the lives of these youth.[18] For some families, the intensive skill building combined with unconditional care gives them the ability to get the help needed for both parent and youth without having to see their child 'placed' elsewhere. For others, the assumption which needs to change is that if a parent at one time is unable to parent a child, he or she should never again be considered a viable option. A common example of this is where a parent has a substance abuse addiction. In programs based on individualized and tailored care, family reunification has often been a result of a re-consideration of a case worker's

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placements or multiple family moves; some families fear system involvement or feel powerless to advocate for their children; some family members just don't know their child is in need; often relatives cannot find their lost children.

16 Mormon Church genealogists estimate that the average American has between 100 – 300 relatives.

17 Two such programs are the "Massachusetts Families for Kids" program in Roxbury, MA. and the "You Gotta Believe" program in New York City.

18 Family Group Conferencing ("FGC") is a process where families assume a central role in planning for their children. A social worker refers a family to an FGC facilitator. The facilitator then works with the child's parents or relative caregiver to identify other extended family members and support people who should be invited to the conference. During this period the FGC facilitator also contacts service providers who can provide pertinent information regarding the well-being of the youth. The family and their support network meet to develop a plan aimed at assuring the well-being of the child. Often the focus is to develop a permanent plan, but other times the family may choose to focus on other more immediate needs, such as treatment plans or visits with family members.

initial decision that a parent was the reason for the problem and should never be looked to as a part of the solution.

Another very critical difference in approach involves continued contact with family members. One Washington state youth interviewed described being prohibited from having contact with parent[s] and siblings as a key reason why he acted out, ran away and ended up having multiple placements.[19] In the promising practice approaches, when youth are outside of the home, such as in kinship or foster care, emphasis is put on encouraging them to maintain contact with their biological parents and/or other extended family members, unless specifically contra-indicated by safety concerns. Youth are regularly updated about reunification or other permanency options and are prepared to transition when the time comes. They are also provided help in maintaining relationships with siblings through visits and shared activities whenever possible. Both parents and youth are helped in dealing with issues of separation and loss.

INTEGRATED SERVICES FOR MULTIPLE NEEDS

In addition to a greater emphasis on community care and family participation, interviewees and the literature uniformly speak to the need to restructure the system for delivering services to youth with emotional and behavioral disturbances and their families across child-serving systems.

Youth and families with multiple needs often do not get the array of services they need at the time they need them. The services they do get are driven by the 'door' through which they enter the system: Mental Health, Substance Abuse, Juvenile Rehabilitation, Developmental Disabilities, and Child Welfare. Each system is responsible only for assessing needs related to its services and providing the services over which it has control. No single entity is responsible for coordinating care based on a plan that focuses on the 'whole child'.

This fragmented approach to serving multi-needs youth means that services are not managed in an integrated way toward a clear outcome. Families must deal with different assessments, different eligibility criteria, different reimbursement rates, different intervention philosophies (Mental health traditionally uses an episodic, crisis intervention approach yet other systems need them to partner with preventative, long term assistance.) Services are not managed cohesively, and collaboration and coordination among child-serving systems is difficult to achieve.

Interviewees suggest structural reform is needed. While some look to models such as that of New Jersey where all services for multi-needs youth are put under a single umbrella administration which then contracts with service providers, others express concern that this approach can result in increased administrative costs

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[19] Interviews of two youth where traditional practice led to them being 'hard to place', then use of the approaches outlined in this section led to permanency, are summarized in Appendix A.

and too much bureaucracy, where the emphasis is on measuring process indicators (i.e. how much time is spent in collaborative meetings) rather than focusing on values and permanency outcomes.
Regardless of structure, what is fundamentally important is that all child-serving agencies have common values and agreement about what a good outcome is and that whatever complex needs assessment tool is used leads to an integrated and individualized service plan. To do this, there must also be a single entity that has overarching responsibility to make sure that youth and families get the services they need, that care is coordinated and that responsibility for achieving outcomes is clear, without driving up costs. Family satisfaction should be measured in order to ensure that the family feels services were collaborative, but that the process didn't get in the way of common sense and efficiency.

EVIDENCED-BASED PRACTICES

Interviewees and the literature strongly suggest that improvements in the quality and effectiveness of services for 'hard to place' youth will more likely result from using approaches informed by evidence (validated by research) rather than by traditional, popular or familiar practices. In addition, the evidence overwhelmingly speaks to the need to recognize foster children as a specialized population with unique and distinctive problems and needs.

Youth who are aggressive, defiant and disruptive are more likely to experience placement instability than those without these problems. The empirical evidence is confirmed by the perceptions of staff working in child welfare, and foster parents, because they find youth with externalizing disorders the most difficult to place and support. In general, most studies on the effectiveness of outpatient interventions for this population support behavioral and cognitive behavioral therapy over non-behavioral therapies. The successful treatment approaches focus on problems of aggression, peer rejection, defiance and poor school behavior - the same problems that, if left untreated, will diminish the likelihood of children achieving a stable home setting. (*Marsenich, 2002*)

Whether youth must be served in an institutional setting, such as adjudicated youth serving sentences in juvenile correctional facilities, or they can be served in the community, providing services that best address the needs of a youth and family at the time they need them, ensuring the effectiveness of the service in achieving the desired outcomes (e.g., child well-being, family well-being, stability and permanency of family relationships), and adherence to the proven treatment models are all critical.

Three intervention models in particular have demonstrated effectiveness with youth who are disruptive, aggressive, and defiant and who experience unstable placements – the types of youth who are the focus of the Committee's work. These evidence-based practices are wraparound service strategy, therapeutic foster care ("TFC") and multisystemic therapy ("MST").

Wraparound is a family and team-driven strengths-based approach where intensive and comprehensive social, mental health and health services are "wrapped around" children and their families (biological, adoptive and/or foster families) to reinforce natural family supports.

Therapeutic or treatment foster care involves having the foster parents assume the role of primary interventionists and providing foster parent training, clinician support and consultation, case management, and family therapy. (*Marsenich, 2002*)

MST is not a unique therapy, but a collection of promising techniques, such as the pragmatic family therapies, cognitive-behavioral therapy, and problem-solving and skills training. Many of the services are provided in either the home or a familiar community setting to enhance family cooperation and promote learning and implementing new behaviors in the family's natural setting. A set of intervention principles and change strategies guide this approach, which assumes that there are different paths to the same behavior, and therefore, treatment plans can be flexible. (*Henggeler et al., 1998*)

These evidence-based interventions, together with new emphasis on reaching out to extended family to avoid 'placement', are the promising practices to which states and providers are turning to better address challenges long believed to be intractable. In addition to increasing permanency and improving behavior, none of these interventions is heavily dependent upon professional staff. This is important given staffing demands in child welfare and mental health systems, and given the assumptions often made by professional staff about who should be involved in decision-making and the role families should play.

It is important to keep in mind that the values and principles which underlie these approaches are instrumental in their successful outcomes. In other words, it is not a program per se that DSHS should look to replicate, but those underlying values and principles, and the core program elements based on them which research has now shown are effective.

1. Wraparound

Wraparound is a family and team-driven, strength based approach where individualized supports and services are designed incorporating needs and strengths across multiple life areas or "life domains". Life areas generally include Home, Family, Safety, Educational/Vocational, Social/Recreational, Medical, Legal, Spiritual/Cultural, Financial, and Psychological/Emotional. Intensive and comprehensive services are "wrapped" around children and their families (biological, adoptive and/or foster families) to reinforce natural family supports, promote safety, stabilization and permanency.

This values-based approach involves a flexible planning process, resulting in individualized plans created based on the unique strengths and preferences of family members and natural supports. Services are home and community-based, designed to promote success, stabilization, safety and permanence, with an emphasis on safety and unconditional care. Outcomes are measured on an individualized and aggregate basis.

Over the last decade, the wraparound model of providing behavioral healthcare services has evolved as a way to help youth with the most serious emotional and behavioral problems. This service delivery model is characterized by care that attempts to meet the total needs of each youth and family to achieve positive outcomes. Unlike the more traditional categorical approaches, the wraparound model utilizes a community-based, integrated, flexible, multi-system and multi-service approach to care.

Interviewees note that the term wraparound is used by many programs in describing their services, even though elements critical to the approach are not utilized. For example, some intensive behavioral services describe themselves as wraparound even though the family and the youth are simply told what is happening, as opposed to being equal partners in the decision-making process. Others describe their programs as wraparound even though all families receive the same services (this is not individualized and tailored care) or the program takes place in a group care or hospital setting (wraparound was designed to be an alternative to institutional placement).

The research literature and interviewees underline that there are a core set of values, elements and practices which must be part of this intervention. Family-centered decision-making identifies needed services; family, professionals and advocates work together as a team; strengths are identified and used to determine needed services and supports to meet family goals; and flexibility will allow for different set of services and supports used or even created for each family that may change over time. Community-based, unconditional care is at the center of this intervention approach.

Burns and Goldman (1999) cite ten essential elements that define wraparound in the executive summary to a Substance Abuse and Mental Health Services Administration (SAMHSA) best practice publication. The elements are:

1. Services must be community-based.
2. Services must be individualized; strength based and designed to meet the needs of children to promote success, safety and permanence in home, school and community.
3. The process must be culturally competent.
4. Families must be full and active partners in every aspect of the process.

5. The approach must be team-driven, involving the child, family, natural supports, agencies and the community services working together to develop, implement and evaluate the individualized plan.
6. The teams must have adequate, flexible approaches and flexible funding.
7. Individualized plans must include formal services and informal resources.
8. An unconditional commitment to serve children and families is essential.
9. The process should be interagency, community-based and collaborative.
10. Outcomes must be determined and measured for the child/family, the program and the system.

The Wraparound Milwaukee program is often cited as a successful implementation of this approach. It incorporates five basic principles related to their service delivery to youth with behavioral disorders and mental illness who referred from both the child welfare and juvenile justice systems: 1) Address problems in youth's natural environment; 2) Work with and listen to the whole family, especially parents under the belief that families know best what they need; 3) Provide individual services based on the needs of each youth and family rather than expecting child and family to fit into a treatment approach that has not been specifically designed for them; 4) Focus on strengths, aptitudes, interests and desires and 5) Build a supportive system using family members, friends, interested adults who care and are willing to provide support and care.

This wraparound approach uses blended funding and "capitated rate" financing and includes care coordinators, child and family teams, a service provider network and a mobile crises team. Social services, the juvenile court, mental health, public defenders, law enforcement, education, and others interested in child welfare must make a formal commitment to participate in coordinated case management, demonstrate their role, and participate in the funding decisions for services to youths and families via interagency WRAP Services Teams.

The care coordinators are the heart and soul of the program. (*Kamradt, 2000*) The first visit of the care coordinator focuses on establishing rapport, hearing the family's story, identifying strengths, developing a crisis safety plan and exploring what has worked for the family in the past. The care coordinator assures the family that the program will do "whatever it takes" to support the child and family.

During the coming weeks, the care coordinator works with the family to develop a child and family team -- a collection of individuals who can support the family. A successful team might include family members, friends, relatives, mentors, church members, mental health workers, coaches, medical professionals, teachers, school personnel, probation officers, child welfare workers and family

advocates. A program psychologist might be involved on the team if the youth is high risk (e.g., a sex offender or a fire-setter).

The goal of the team is to determine the family's needs, develop strategies to meet those needs, prioritize strategies, determine desired outcomes, establish a plan and assign roles and tasks. The family care plan could include anything from acquiring a new apartment to automotive repair lessons, from respite care to transportation services, from emergency food to substance abuse treatment. (*Paccione-Dyszewski, 2002*)

During its four years of service delivery, Wraparound Milwaukee dramatically reduced the use of restrictive placements, including an 80 percent decline in inpatient hospitalizations and a 60 percent reduction in residential placements. Clinical outcomes assessed by standard measures have improved significantly for youth in the program and a reduction in recidivism rates for a variety of youth offenses has also been noted.[20]

2. Treatment Foster Care (also known as Therapeutic Foster Care)

Treatment Foster Care ("TFC") is a family-based alternative to residential, institutional, and group care for children and adolescents with significant behavioral, emotional and mental health problems. It emphasizes strategies to address four key functions which its researchers have found affect outcomes: (1) close supervision; (2) discipline; (3) adult-youth relationships; and (4) association with deviant peers.

(*The following program description is an abbreviated version of materials drafted by Dr. Patricia Chamberlain of the Oregon Social Learning Center ("OSLC").)*

Developed in 1983 at the OSLC to help juvenile offenders whose families were unprepared to care for them, the TFC model was adapted in 1986 to serve youth with severe emotional and behavioral problems who were leaving the State hospital. These children were 9 to 18 years old and had been hospitalized for most of the year prior to treatment in TFC. Based on that work, OSLC began treating youth ages 4 to 18 who were referred from the mental health and child welfare systems, were eligible for Medicaid services, and had previously had a number of out-of-home placements.

In 1996, OSLC began a TFC program for adolescents with developmental disabilities and a history of acting out sexually. The most recent research focus for the TFC approach is on adolescent females (12 to 16 years old) with a history of criminal behavior and severe emotional problems.

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[20] An important distinction between the Milwaukee wrap around program and others is that all the youth participating in the Milwaukee program were referred by the Courts.

In the TFC program, severely troubled youth are placed individually or, at the most, in pairs, in a family setting with two specially trained foster parents for four to 12 months. Foster care families are recruited from the community and trained by TFC program staff. TFC parents are part of the treatment team along with program staff and provide well-supervised placements and treatment. They receive a monthly salary and a small stipend to cover extra expenses. TFC parents implement a structured, individualized program designed to build on the adolescent's strengths and to establish clear rules, expectations, and limits.

Foster parents are trained to establish clear rules, apply discipline such as work chores and learn how to respond without anger to antisocial behavior. During treatment, the adolescent and his or her parents - biological, stepparents and foster alike - receive ongoing psychological counseling. A case manager supervises the entire program and meets with parents weekly. Parents and teachers can call the case manager for crisis intervention or psychiatric services any time of day or night. Parents are telephoned every day to obtain information on the youth's behavior.

In 1991, 40 adolescents were randomly assigned to the Treatment Foster Care (TFC) program, and 40 were randomly assigned to a group care program. The boys, ranging in age from 12 to 17 years, had, on average, 13 arrests each before joining the study. Half had committed at least one crime against a person. In group care, boys lived with 6 to 15 others who had similar histories of delinquency.

The Treatment Foster Care program seems incredibly labor intensive, but it costs less than keeping a juvenile in a group home or in juvenile jail, known as detention. After 12 months, youth in the Treatment Foster Care program had cost the state 70 percent of what it had cost the state to incarcerate them before entering the program, while those in group care cost the state 150 percent of what it had cost the state to incarcerate them before they entered the program. By 18 months, TFC children cost the state 143 percent less than standard group care children. At six months, 12 months, and two years after leaving the program, the TFC teens were arrested 50 percent less often than group care teens. The current total cost of six months of TFC per teenager is $10,808. Group care boys reported that they spent an average of 79 minutes per day unsupervised, while TFC boys reported an average of 12 minutes per day unsupervised.

The following is the story of one boy in the TFC program. Eddie, 14, had been in group care since age 7, when he was removed from his home. From the time he was a baby until age 6, Eddie had been sexually and physically abused by his father. One day, after his mother took the children and fled from his father, Eddie brutally attacked his 3-year-old brother. His mother, overwhelmed by her own circumstances, asked Oregon's Child Welfare Agency for assistance. He was placed in foster care.

Eddie lived in five foster homes in six months. Attempts to put him in long-term residential care, including adoption, failed. He was eventually put in a county

detention facility, where he had been for eight months. He felt people hated him and were out to get him, he felt isolated from his peers, his moods swung erratically, he was impulsive, he was obsessed with violent material, he had angry outbursts that included physical attacks on others, he had sleep problems and he made inappropriate sexual comments. He had been charged with three counts of assault. Despite normal intelligence, Eddie had not attended public schools since the first grade.

In preparation for Eddie's placement, staff provided training for a foster parent, explained to Eddie how the system worked, introduced him to his therapist, obtained psychiatric consultation to review medication, set up school planning and consultation and initiated contact with Eddie's mother. After Eddie joined his foster family, family therapy with Eddie and his mother began. He had regular home visits, as well as psychiatric evaluation and medication management, school consultation and recreational activities that emphasized teaching him social skills to improve relationships with his peers.

During the first three months, Eddie had several crises in which he would become extremely angry and verbally abusive. He ran away for two to three hours at a time. The staff and parents applied consequences every time he broke a rule. In cases of extreme anger, he was put in detention for 24 hours. His individual therapist helped him understand that his outbursts were triggered by his feelings of failure, for which he had zero tolerance, and thoughts that others viewed him negatively. After six months, Eddie began to believe that his TFC family and staff valued and cared about him.

Eddie had problems in school at first. He began with one period a day and eventually moved to a full day of school. When Eddie was disruptive - swearing at teachers and students, running in and out of the classroom, refusing to move or be quiet - the school called the case manager, who removed him. During the summer, he received tutoring and attended a soccer camp. By the following January, he no longer swore in school and would not hang out with delinquent peers because he felt they would get him into trouble.

After 17 months, Eddie was able to be reunited with his mother. His aftercare program included continuing social skills training, individual and family therapy, his mother becoming involved in a support group for parents (she was eventually invited to become a paid parent advocate) and ongoing psychiatric medication management. Eventually, Eddie no longer needed his prescription of lithium and halidol.

One advantage of TFC is that a youth’s program can be individualized to fit his or her needs, problems, and strengths. While in TFC, a youth’s biological or adoptive family (or other family resource) is very much involved in the program. Not only do they have continual input into their child’s treatment and care, but they are also counseled on parenting skills that will support their child’s progress after the program is completed.

3. Multisystemic Therapy (MST)[21]

The MST approach is a family and community-based treatment that addresses the multiple causes that lead to youth being at high risk of out-of home placement. It works to strengthen the support systems that surround youth and includes a focus on "family preservation through home-based services". Their philosophy includes the belief that the most effective and ethical route to helping children and youth is through helping their families who are viewed as valuable resources, even when they are characterized by serious and multiple needs.

The goal of the MST approach is to provide an integrated, cost-effective family-based treatment that results in positive outcomes for adolescents who demonstrate serious antisocial behavior. MST focuses first on improving psychosocial functioning for youth and their families so that the need for out-of-home child placements is reduced or eliminated. To accomplish this task, MST addresses the known causes of delinquency on an individualized, yet comprehensive, basis. MST interventions focus on the individual youth and his or her family, peer context, school/vocational performance, and neighborhood or community supports.

MST strategies appear to work well for complex needs youth as well as juvenile offenders. Both generally carry one or more diagnoses, experience school failure at high rates and are frequently placed in restrictive settings because their behavior is perceived as a threat to the community. (*Schoenwald and Rowland, 2002*)

In Simpsonville, South Carolina, the MST program provides services to serious, violent, and chronic juvenile offenders at imminent risk of out-of-home placement. The Simpsonville program has reduced recidivism rates substantially. (*OJJDP Bulletin, 2002*)

In Columbia, Missouri, the MST approach was used with adolescent sexual offenders. Recidivism data approximately 3 years after treatment showed that significantly fewer participants had been rearrested for sexual offenses (12.5 percent versus 75 percent) and that the frequency of sexual rearrests was significantly lower in the MST condition (average = .12) than in the individual counseling condition (average =1.62). In addition, the frequency of rearrest for nonsexual crimes was greater for adolescents who received individual counseling (average = 2.25) than for the adolescents who received MST (average = .62).

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[21] Functional Family Therapy has also been identified as a family-based intervention and prevention program that adopts a multisystemic perspective and treats a broad range of youth exhibiting delinquent and/or criminal behavior. This intervention has been shown to reduce recidivism or the onset of offending more effectively than other programs and reduces treatment costs below costs associated with more traditional interventions. (*Alexander, et al, 2000)*

Findings from this study should be considered tentative because the sample size was only 16 sexual offenders. (*Henggeler, 1995*)

MST defines success in terms of reduced recidivism rates among participating youth, improved family and peer relations, decreased behavioral problems, and decreased rates of out-of-home placements.

Recent research indicates that when compared with youth who received "usual services", i.e., court-ordered stipulations such as curfew, school attendance, and participation in various agency programs that were typically monitored by probation officers -- youth who received MST had fewer arrests, reported fewer criminal offenses, and spent an average of 10 fewer weeks in detention during a 59-week follow-up.

In using MST to address issues of substance abuse, in comparison with delinquents and families receiving usual services, youth in the MST condition evidenced decreased substance use at post-treatment and had 26 percent fewer rearrests and a 40-percent reduction in days incarcerated at an approximately 1-year follow-up. Cost analyses have shown that the costs of MST were nearly offset by savings incurred as a result of reductions in days of out-of-home placement during the year following referral.

As a family-based alternative to the hospitalization of youth presenting psychiatric emergencies, community-based emergency psychiatric services are being blended with MST to safely prevent hospitalization and reduce the symptoms and environmental factors precipitating the crisis.

Leading child treatment researchers concur that MST is a well-validated treatment model. (*Schoenwald and Rowland, 2002; Kazdin and Weisz, 1998*) Evidence also suggests that MST may be more cost effective than traditional services provided to youth at risk of imminent placement and their families. A study conducted by the Washington State Institute for Public Policy (“WSIPP”) in 1998 found MST was the most cost-effective intervention for juvenile offenders among 16 programs evaluated.

The success of MST is based on several factors, including its emphasis on addressing the known causes of delinquency; the provision of treatment services where the problems are -- in home, school, and community settings; and a strong focus on issues of treatment adherence and program fidelity. (*Henggeler, 1995*)

PROMISING PRACTICES IN WASHINGTON STATE

There are several areas of the state that have changed their assumptions and approaches. They are now serving complex needs youth in the community, providing a range of services in an integrated way and including the family as equal partners in decision-making. As a result, they are achieving excellent

outcomes in terms of avoiding multiple, expensive placements for youth with serious emotional and behavioral disorders. Three Regional Support Networks ("RSN")[22] in particular are recognized: the Pierce County RSN, the Clark County RSN and the Chelan-Douglas RSN; and three programs: FAST and WRAP services provided by Catholic Community Services and the King County Blended Funding Project. (*See Appendix B for additional information about how each of these programs was initiated, how their services are funded, how the public is involved and what their outcomes are.)*

The programs noted have completely redesigned their system of care around how services should be delivered to children and their families. Their systems are guided by a set of basic values and operational philosophies giving families an opportunity to make the decisions as to what should happen and what they need. They do not have a "one size fits all" menu of services. Instead they work creatively together through a wraparound process to develop plans that meet a family's identified needs, providing an intervention that is individualized and tailored.

These approaches are designed to provide a broad range of community services and supports tailored to the specific needs of the individual child or family, achieved through team planning and cooperative agreements, with flexible payment structures or pooled resources from multiple service systems. Youth involved in these approaches are the most in need, highest cost youth receiving services from multiple systems.

Using this approach, professionals and natural supports (e.g., extended family; friends; church; teachers) listen to the families, assisting the youth and family members in identifying strengths, and prioritizing what specifically a family needs in order not to have to be dependent on the public system. Working as a team, they then figure out a way to get those services and support to them.

Crisis stabilization strategies are implemented without delay, where families can receive services for their child in an emergency (i.e. immediate intensive in-home supports, respite care, therapeutic foster bed, and psychiatric support) to truly stabilize the situation for the family. Agencies offer services to families and youth 24 hours a day. With few exceptions, services are provided in the community, home or school.

Parents, as well as other family members, are partners in the process, valued and involved in every phase of the intervention (assessment, planning, services/supports and evaluation). There are parent organizations, parent partners, and parents who serve as a respite pool.

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[22] RSNs are county entities that provide community inpatient and outpatient mental health services in Washington State. Some are a single county (e.g., King); others have joined together through interlocal agreements and range from 2 to 11 counties.

In the services provided by the RSNs, the entire rate for services is flexible within a total capitated rate that varies from RSN to RSN (i.e., it can be used flexibly within federal and state guidelines to meet needs). In King County, there are flexible funds for families and agencies to access for needs that arise along the way. The programs re-engineered existing resources and created or contracted out for services families and their teams agreed were needed in order to reach permanency, safety and stability outcomes. Funders (i.e., RSNs) have also used inpatient savings to develop needed services or have re-allocated funding from services that that did not demonstrate positive outcomes with this population.

These programs are all serving 'hard to place' youth, youth with severe mental illnesses, self-harm, acute suicidal behaviors; youth with violent, assaultive behaviors; sexually aggressive youth. The approaches used are successfully diverting them from psychiatric hospitalization, group care and multiple placements. Perhaps more importantly, many youth with histories over several years of high utilization of hospitalizations, institutional placements, and multiple foster and group care placements are safely returning to immediate and extended family homes without recurrence of placements or hospitalizations. For youth nearing age 18 who traditionally would "age out" of the system without a family to live with, essential re-connections with family are also being made prior to the youth leaving the system.

Those leading these efforts emphasize that all child serving agencies must work together (Child Welfare, Schools, Mental Health, Developmental Disabilities, Substance Abuse, and Juvenile Rehabilitation) and find common values to develop a strong system of care. They share responsibility for all of the youth referred. No one is allowed to say 'not our kid'. They would like to see this kind of collaboration at the State and local levels to foster more of these kinds of integrated, collaborative approaches.

All of these model frameworks have common elements in their approaches and strive for common outcomes.

Critical Components of Effectiveness

- Unconditional care (whatever it takes to stabilize and meet the needs of the youth and family)
- A focus on child and family strengths as well as preferences
- A perspective that the family is valued, and not viewed as 'the cause of the problem'
- Highly individualized treatment plans (often referred to as "individualized and tailored care")
- Multi-modal treatment
- Services are driven by the needs of the family and youth and are coordinated in a multi-agency, collaborative way, based in the community

- Both the youth and parents are included as equal decision-making partners in the development of treatment plans
- Child and family teams involve more natural supports than professionals
- An emphasis on keeping connected or re-connecting youth with those who care the most about their well-being: family and relatives
- The timeframe for action is defined by the needs of the youth (a youth who has a history of lasting only hours at placements requires faster intervention) and family, not on the needs of the caseworker or court
- Services, programs and agencies are responsive to cultural context and characteristics (often referred to as "cultural competency")
- Access to support systems and problem solving is on a 7 day a week, 24 hours a day basis

Outcomes

Historically, success in serving youth has been measured in terms of services delivered, or on process indicators, rather than child outcomes achieved. While it is valuable to record and track what services have been provided, it is critical to track the youth outcomes achieved through the provision of those services.

Thus measuring success by whether a placement is found is measuring a service delivered. Worse yet is measuring any placement as a success, without assessing the degree of appropriateness of the placement in terms of the youth's needs.

System outcomes include[23]:

- Reduction in cost of service
- Reduction in the number and cost of placements
- Reduction in utilization of restrictive settings
- Reduction in utilization of group residential and out of state placement
- Decrease in Foster Parent attrition /increase in Foster Parent satisfaction
- Increase in Foster Parent recruitment
- Increase in funding for interventions that are proven & decrease in others
- Expedited permanency

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[23] Other indicators, as opposed to outcomes, include: increased level of collaboration across systems and agencies; increased community engagement; increased youth involvement in placement decisions; increase in use of family meetings (i.e. Child and Family Teams, Family Group Conferencing, etc.); and increase in number of and pace of successful extended family connections.

Youth and Family outcomes include:

- Achievement of child and family's goals
- Decrease in aggression, suicidal behavior, sexual acting out, fire-setting and other behavior problems
- Decrease in symptomology (depression, psychotic, anxiety)
- Reduction in hospitalization
- Decrease in use of alcohol or drugs
- Decrease in delinquent or criminal activity
- Improvement in positive relationship with parents
- Increased satisfaction with services
- Improvement in social adjustment at home, at school, with peers
- Prevention of homelessness
- Improved school attendance and performance
- Prevention of out-of-home placement
- Stronger family support and cohesion
- Increase in coping and problem solving
- Decrease in family strain/burden

Funding

The literature and interviewees express a strongly held view that resources being used for traditional 'placement' approaches should be re-directed toward these evidence-based or proven practices that keep youth connected to their communities, their homes and their schools.

Interviewees recommended tracking the cost per youth currently of resources spent in multiple placement crises ("we'll pay you whatever you need to take him"), hospitalizations, BRS services, juvenile detention and corrections, 'overflow' and out-of- state placement, to be able to compare to the cost of various promising practices.

The RSNs are themselves working on strategies to reinvest resources from expensive restrictive placements to more cost-effective community-based services and would like to see this type of reinvestment encouraged in State level budget decision-making. For example, they use savings for concrete needs the youth and family have that don't fit neatly into categorical budget, but often can make a big difference. Interviewees mentioned the importance of the collaborative, do 'what it takes', 'sweat the small things', pooled funding or flexible rate approach allowing them to fund things like money to participate in an after school program, money for a security deposit on an apartment or money to license a pet from the pound. These are examples of assistance provided that in traditional programs would be seen as either inappropriate or impossible to fund.

An example of the pooled funding approach is the King County Blended Funding Project, designed to overcome three barriers common to child-serving systems: 1) inflexibility of categorical service systems, 2) fragmentation of financing and case management, and 3) hierarchical relationship among systems, providers, and families.[24] The Blended Funding Project is a cooperative effort of the King County Division of Mental Health, the Division of Children and Family Services, school districts, and parents, to pool funds to deliver efficient and flexible services to children with severe emotional and behavioral problems.

In the Blended Funding Project, participant systems contribute directly to a pool. These dollars are directly available to child and family teams. Providers and other community resources have direct involvement with child and family teams. The team has the authority to purchase resources, create and implement the care plan, guided by the values and principles described below:

Values:

- Responsibility for children and families is shared by systems with communities.
- Parents are involved at all levels of operations, including managing the care of their children.
- Those closest to the child best know the child's needs.
- All services are designed individually to meet the unique needs and strengths of each child and family.
- Children and families have needs in all life domains and planning is comprehensive.

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[24] The Dawn Project in Marion County, Indiana is another example of the shared funding approach. The Dawn Project developed a state-level consortium of agencies for pooling mental health treatment dollars to serve seriously emotionally disturbed children and adolescents through a capitated care management entity. Consortium agencies included education, child welfare, juvenile justice, and mental health and substance abuse services.

The administrators of the four community mental health centers formed a new nonprofit managed care corporation; the single point of entry for all children who are referred. The Project uses family-centered, community-based, culturally competent, strengths-based, individualized services for kids with serious emotional disorders and their families. All agreed funding is flexible and responsive to a family's range of needs. They summarize their results as:

- Assisted Dawn Project payers in avoiding more than $2 million in placement costs.
- Documented a reduction by 50% in the cost of residential care.
- Documented decreases in length of stay in residential care compared to the client's previous year.
- Managed costs while using existing community resources to provide the needed care.
- Advanced the abilities of families and parents to participate in community-based teams.
- Provided parents and families the opportunities for access, voice, and ownership.
- Documented significant improvement in the Child and Adolescent Functional Assessment Scale (CAFAS) scores across all client functional domains.
- Moved clients to less restrictive levels of care without compromising their care.
- Documented the length of stay in the program for those who graduated at 11 months.
- Enhanced the quality of life for families.

- Families should not have to navigate multiple systems and case managers to get needs met.

Principles:

- Children and families have access to a comprehensive array of services for all life domains.
- The unique needs and strengths of each child are used as the guide for the development of a care plan.
- Services are provided in the least restrictive and most normative environment that can meet child/family needs.
- Planning and decisions are made by a child and family team, with the family as full participants in the process.
- Services from all systems are coordinated and arranged by a single care manager with the authority to purchase services in any system.

IV. THE WASHINGTON STATE LANDSCAPE

There are a variety of factors which may create barriers in meeting the needs of this population – age of consent laws for treatment; Federal and State policies about the use of locked facilities; determinate sentencing laws; sovereign immunity/joint & several liability; sex offender notification laws; and local zoning regulations. The Committee initially reviewed each of these potential barriers largely in the context of the status quo in terms of how services have been traditionally provided to 'hard to place youth', not through the lens of the promising practices approaches outlined in this report. Many of these issues, liability and community siting in particular, remain as significant barriers regardless of whether DSHS continues to use a "placement" model or adopts the recommendations in this report. Others, such as locked facilities and determinate sentencing laws, would presumably no longer pose real barriers if the practice changes recommended in this report are adopted.

Age of consent for mental health and chemical dependency treatment

13 is the age at which youth in Washington state can seek or refuse outpatient mental health and chemical dependency treatment and inpatient mental health treatment. For inpatient chemical dependency treatment (RCW 70.96A.235), minors require parental consent unless the minor meets the requirements of a CHINS petition.

Unless involuntarily committed, if a youth does go to a treatment facility or residential group care on his or her own or at the request of his or her parents, the youth may not be prohibited from leaving by the use of locks or other secure mechanisms. (*See Locked Facilities, below*)

To meet the grounds for involuntary commitment for minors under age 18, the minor must be "as a result of a mental disorder, in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and not receiving such care as is essential for his or her health or safety." RCW 71.34.080

If the youth does not meet medical necessity criteria, parents can file "Child in Need of Services" (CHINS)[25] or "At-Risk Youth (ARY)[26] petitions, pursuant to the

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25 "Child in need of services" means a juvenile:
(a) Who is beyond the control of his or her parent such that the child's behavior endangers the health, safety, or welfare of the child or other person;
(b) Who has been reported to law enforcement as absent without consent for at least twenty-four consecutive hours on two or more separate occasions from the home of either parent, a crisis residential center, an out-of-home placement, or a court-ordered placement; and
(i) Has exhibited a serious substance abuse problem; or

"Becca Bill". The 1995 At-Risk/Runaway Youth Act named after a youth who was murdered after she ran away from home, authorizes juvenile court intervention for youth who are beyond their parents' control due to chemical dependency, as chronic runaways, or for other behaviors which create a serious risk of harm to the health, safety, or welfare of the child or another person. CHINS and ARY youth can receive chemical dependency assessments and referral for voluntary, parent-initiated, and involuntary treatment. From 1995 to 2000, approximately 1,000 youth (about 200 per year) were admitted to treatment under the auspices of the Becca Bill.

Parents who have struggled with children who need medications but refuse to stay on them express frustration at their helplessness in being able to stabilize behaviors. They have to wait until their child threatens real harm before the youth can be required to comply with either inpatient or outpatient mental health treatment. Some also mention that they are still liable for their children's actions, if the child does do something violent or destructive.

Some interviewees compared the issue to medical treatment, and articulated it this way, "We don't allow 13 year olds to even make a decision about their tonsils, but we think they are mature enough to make a decision about whether they have a significant mental illness and how best it should be treated."[27]

Others were more concerned that the mental health system as a whole does not place a priority on children, and that the real issues have to do with (1) mental health professionals who make the assessments for involuntary treatment not being trained in children's mental health; and (2) the criteria for involuntary commitment being too narrow.

(ii) Has exhibited behaviors that create a serious risk of harm to the health, safety, or welfare of the child or any other person; or
(c)(i) Who is in need of: (A) Necessary services, including food, shelter, health care, clothing, or education; or (B) services designed to maintain or reunite the family;
(ii) Who lacks access to, or has declined to utilize, these services; and
(iii) Whose parents have evidenced continuing but unsuccessful efforts to maintain the family structure or are unable or unwilling to continue efforts to maintain the family structure. RCW 13.32A.030.

26 "At-risk youth" means a juvenile:
(a) Who is absent from home for at least seventy-two consecutive hours without consent of his or her parent;
(b) Who is beyond the control of his or her parent such that the child's behavior endangers the health, safety, or welfare of the child or any other person; or (c) Who has a substance abuse problem for which there are no pending criminal charges related to the substance abuse. RCW 13.32A.030.

27 The quotes used throughout this report reflect the personal views of the interviewees and are not the official position of either DSHS or the Select Committee.

Many voiced a concern that there are not enough beds for inpatient treatment now, so that raising the age to have more children in treatment is only going to exacerbate the problem of parents having to wait months to find a bed. Currently, there are over 300 youth on a waiting list for chemical dependency residential treatment[28] and parents describe waiting for months for an inpatient mental health bed.

Still others argue that the process of At Risk Youth Petitions already provides the vehicle for mandating treatment for youth where appropriate, but that most parents don't know how to use it.

Some express a concern that opening up the debate about raising the age of consent in this arena could lead to a revisiting of the age of consent for services related to family planning.

Interviewees who are involved in new approaches for addressing the needs of youth with severe mental health or behavioral disorders articulate the perspective that inpatient treatment should rarely be needed if other appropriate community-based, wraparound treatment is available.

Others providing services voiced concern about the length of time it takes to access court approval of psychotropic medications for dependent children who are under the age of consent. These youth have to have court approval for medication. Interviewees indicate it sometimes takes more than six weeks after the physician has prescribed the medication for the DCFS worker to get it scheduled for court approval. While these youth are waiting for their medication to be approved, they "blow out" of their living situation. Raising the age of consent would mean that more dependent youth would have to have court approval, thus potentially exacerbating this problem.

Lastly, many expressed the view that the reason the age of consent is at 13 is to protect adolescents from inappropriate actions by their parents, that history is replete with examples of parents institutionalizing their children because of disobedience, behavioral disorders or sexual orientation.

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[28] Becca youth and their families face long waits for admission to intensive inpatient treatment. According to DASA, 58% in a recent study waited more than one month, and 27% waited three months or more. As a result, many youth miss the prime window of treatment motivation. The longest waits are for Level II Secure facilities, those that provide treatment for youth with the highest level of clinical need.

While an overwhelming majority of Becca youth require further chemical dependency and/or mental health treatment once intensive inpatient treatment is completed, Recovery House beds -- which support long-term recovery, re-entry into the community, and improvement in major life competencies -- are in very short supply. Per DASA, intensive inpatient programs report they discharge 65 youth (Becca and non-Becca) each month who would be appropriately placed in recovery house settings. However, there are only 28 recovery house beds available statewide.

For those who advocate raising the age of consent, the preferred approach is to raise the age at which a youth can refuse treatment or decline to remain in a secure treatment program to age 16, but to clearly maintain a youth's right to seek certain types of treatment (chemical dependency, mental health, family planning) without parental consent at age 13, as is currently the law.

Locked Facilities

Unlike some states, Washington does not have locked group homes or residential treatment facilities available for placement of youth considered to be status offenders[29]. This category includes youth adjudicated as dependent pursuant to RCW chapter 13.34, CHINS or ARY pursuant to RCW chapter 13.32A, or truant pursuant to RCW chapter 28A.225. Unless an adolescent is involuntarily committed under the mental health laws or voluntarily enters a chemical dependency or mental health treatment program, placement of a high-risk youth in such a facility is not an available option in this state.

Children taken into custody by DSHS because of abandonment, abuse or neglect cannot be detained in a secure detention facility as part of a dependency proceeding. RCW 13.34.060.

In addition, the "Becca" Bill prohibits placing youths in CHINS proceedings "in a secure residence as defined by the federal Juvenile Justice and Delinquency Prevention Act of 1974" ("JJDPA"). RCW 13.32A.180. The JJDPA, 42 U.S.C. 5633, mandates that as a condition of some block grant funding, the state must provide that "such non-offenders as dependent or neglected children shall not be placed in secure detention facilities". These are broadly defined as "any public or private residential facility" which "includes construction fixtures designed to physically restrict the movements and activities of juveniles or other individuals held in lawful custody in such facility."[30]

However, state law does provide authority for the placement of runaway youth in a secure crisis residential center for up to five days.[31] Such youth may be placed

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[29] Status offenses involve actions which, if committed by an adult, would not be considered criminal.

[30] In addition, the costs of placement of dependent youth in detention facilities, medical facilities, forestry camps, training schools or secure, locked facilities for delinquent youth are not reimbursed to the state under Title IV-E.

[31] A "secure facility" under this statute is defined as "a crisis residential center, or portion thereof, that has locking doors, locking windows, or a secured perimeter, designed or operated to prevent a child from leaving without permission of the facility staff. A "crisis residential center" means a secure or semi-secure facility established pursuant to chapter 74.13 RCW.

directly into a secure CRC by a law enforcement officer, DSHS or by court order. RCW chapter 13.32A. If the youth is not subject to court jurisdiction at the time of such placement, a CHINS, ARY or dependency petition must be filed. CHINS petitions may be filed by the child, a parent, or the State. ARY petitions may be filed only by a parent.

If the child admitted under this section is transferred between secure and semi-secure facilities[32], the aggregate length of time spent in all such centers or facilities may not exceed five consecutive days per admission. The facility administrator is required to determine within twenty-four hours after a child's admission to a secure facility whether the child is likely to remain in a semi-secure facility and may transfer the child to a semi-secure facility or release the child to DSHS. The Federal government has found that the use of 5 day temporary detention in secure crisis residential centers violates the JJDPA and has imposed sanctions on the state, which may lead to the loss of some federal funds.

Again, interviewees had diverse points of view on this topic.

Some who work directly with youth express grave concerns that by not having the ability to keep youth from running away from facilities, we are allowing them to "basically kill themselves on the streets", and that youth who are homeless, borderline or suicidal are especially at risk.

Others who work directly with youth articulate the position that creating locked facilities is the worst thing we can do to a child because, "it furthers distrust between youth and the adults in their lives and lets providers off the hook for learning other ways to handle defiant behavior." They further make the case that locked facilities don't lead to long term positive outcomes for youth, producing basically the same clinical outcomes as psychiatric facilities.

Another point of view is expressed by those concerned about the economic disparity of parents, "It is not right that parents with money can send their kids out of state to get them off the streets in an effort to make them safe and those without resources can't."

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32 A "semi-secured" facility is defined as "any facility, including but not limited to crisis residential centers or specialized foster family homes, operated in a manner to reasonably assure that youth placed there will not run away. Pursuant to rules established by the department, the facility administrator shall establish reasonable hours for residents to come and go from the facility such that no residents are free to come and go at all hours of the day and night. To prevent residents from taking unreasonable actions, the facility administrator, where appropriate, may condition a resident's leaving the facility upon the resident being accompanied by the administrator or the administrator's designee and the resident may be required to notify the administrator or the administrator's designee of any intent to leave, his or her intended destination, and the probable time of his or her return to the center."

Some mention the negative ramifications of situations they have seen where a youth hits someone while in a group care facility, gets arrested for simple assault, booked and sent through the court system and ultimately into the JRA system, "simply because the facility staff don't have a tool of a short-term (several hours) locked room to stabilize a youth whose behavior is temporarily out of control."[33]

Others worry that any facility with a lock will be where unruly youth get sent, and will be subject to abuse by the State. Those in regions piloting community-based intensive treatment do not feel that locked facilities are needed and that if created, they will take the pressure off "doing things the right way".

Those who disagree speak to a small subset of youth who truly are at risk of harming themselves or others unless the option of a secure facility is available, and that concerns about abuse can be easily addressed with standards based on national accreditation standards, such as parameters for use of restraints, use of de-escalation room or other approaches, and the use of internal and external review committees.

Lastly, others argue that State statutes for at-risk- youth (ARY) and children in need of services (CHINS), and juvenile offenders already permit commitment to secure facilities under specific circumstances. And that moving to expand the use of secure facilities would move Washington State away from the requirements of the Juvenile Justice Delinquency Protection Act (JJDPA), which requires that a state not institutionalize non-offenders, would be contrary to the intent of the State's Juvenile Justice Act of 1997 intended to move away from incarcerating dependent children and status offenders, and might, under current case law, be unconstitutional.

There is agreement that where locked facilities are used, youth must be given opportunities to learn skills and helped to shape and develop those skills, leading to new adaptive behaviors.

Determinate sentencing

In 1978, Washington passed the Juvenile Justice Act which changed its sentencing structure for juvenile offenders from indeterminate to determinate sentencing and decriminalized status offenses (behaviors that would not be an offense if committed by an adult). One result was that status offenders no longer received treatment and placement services from JRA, but instead from the child welfare system. An additional result was that for children who have finished their

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[33] Group care providers are permitted to use de-escalation or special time-out rooms with spring locks on the doors. Best practice standards encourage the use of a full range of positive interventions before using more intrusive interventions such as physical restraint or de-escalation rooms. (CA: "Behavior Management Guide for Licensed Residential Care Settings")

sentence but for whom appropriate housing can not be found, JRA must release them nonetheless. Other states have indeterminate sentencing, and thus are able to keep youth in custodial settings when they cannot find housing upon release.

Some interviewees, particularly those faced with youth recently released from JRA facilities sitting in their offices with no place to go, feel that the lack of flexibility in being able to keep a youth longer in a JRA facility needlessly creates crises and subjects youth to literally having no roof over their heads.

The countervailing perspective is that without this onus on DSHS to find other placement, youth would languish in institutional settings as they do in other states, which is exactly why the legislature overhauled the juvenile laws in 1978.

Others argue that with appropriate permanency and transition planning, this would be a "non-issue".[34]

Diminution of Sovereign Immunity

An aspect of working with complex needs youth that is different in Washington than in other states is that in Washington there has been some erosion in the doctrine of "sovereign immunity", meaning that a person or agency performing governmental functions in Washington is <u>not</u> immune from being sued. Additionally, Washington has "joint and several" liability, in which a plaintiff can hold DSHS solely responsible for paying an entire judgment, if there is any percentage of fault attributable to the agency.[35]

The common-law tradition of State sovereign immunity was waived by Washington State in 1961, when the State Legislature enacted RCW 4.92.090, allowing the State to be sued in tort to the same extent as a person or corporation.[36] There is no specific grant of either absolute or qualified immunity from tort liability for the State or DSHS caseworkers where a foster child harms property or other people, nor is there a dollar cap on liability for tort claims.

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[34] One interviewee described a situation where a youth classified as a sex offender was released with no place to go and was considered a 'hard to place' youth by DSHS staff. In fact, he had a father in the state who within a day of being notified put the provider in touch with his many relatives in several states, who agreed to take the youth. Had that extended family search been done while the youth was still incarcerated, having to release him on the end date of his sentence would have been a preferred outcome, rather than an obstacle.

[35] With joint and several liability, any defendant can be required to pay the entire judgment, even if its actions were found to be only 1% of the cause of the harm.

[36] This liability is subject to three exceptions: absolute and qualified immunities; discretionary acts; and public duty doctrine.

This is in contrast to the general approach in 35 states of placing a dollar cap on State tort liability[37] and/or continuing to embrace the doctrine of State sovereign immunity.

Although there is no dollar cap on tort claims in California, the California courts have held that the determination by an official of the county Child Protection Services to place a juvenile in foster home was a discretionary decision subject to governmental immunity, precluding any liability on the part of the county where a juvenile was killed while residing in a foster home. *Becerra v. County of Santa Cruz*, 81 Cal.Rptr.2d 165, 68 Cal.App. 4th 1450 (1998).

A similar situation exists in Michigan, where the Department of Social Services is immune from suit for foster care placement because it is engaged in a 'governmental function'. [38] Additionally, recovery by foster parents from the Department for reimbursement for expenses incurred in defending negligence action resulting from alleged wrongful conduct of a state ward in their care is barred.[39]

In New York state, the Court dismissed a case in an action against a county by a woman who was shot in the abdomen by a 14-year-old boy. The Court held that while the boy had been guilty of conduct sufficient to stamp him as a 'delinquent child', the proof did not indicate to a reasonable mind that he would shoot someone. The Court indicated that a county with custody of a delinquent child owes to the community no greater duty than would parents under similar circumstances. The court declared that in the absence of some compelling reason that indicated the necessity of isolating such a child, neither the parent nor the county was under the necessity of keeping him under constant surveillance.

Stating that the tragic incident was a part of the risks a community must bear, the Court concluded that the alternative would be to clap every delinquent suspected of criminal tendencies into an institution or keep him under constant watch, and that this would be an intolerable burden on society. *Staruck v. County of Otsego*, 285 App.Div. 476. (1955).

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37 Ranging from $50,000 (Nevada) to $1,000,000 (Missouri and Nebraska)

38 The State cannot be liable in tort for negligence of persons to whom care of a state ward is entrusted, since such an entrustment results from exercise of a governmental function authorized by law. Op.Atty.Gen.1974, No. 4833, p. 203.

39 There is sovereign immunity from liability in tort and the Department may not enter into any agreement abrogating such immunity. Op.Atty.Gen.1974, No. 4833, p. 203.

However, in *Sebastian v. State*, 250 A.D.2d 260, 680 NYS 2d 370 (1998), the Court held that Department of Social Services employees had sufficient control over a foster child who had known dangerous propensities to establish a common law duty to protect neighbor's minor child from sexual abuse inflicted by the foster child. The DSS officials had both legal custody and supervisory control of the foster child and reports of two psychologists put DSS employees on notice of the child's propensity to harm others.

As with the other issues in this section, opinions are split about this topic. There are those who believe the lack of sovereign immunity forces governmental officials to take greater care in their decision-making and actions. Others feel strongly that concerns over liability color everything, causing centralization of decision-making, hierarchical management and loss of ability to develop creative programs with partners at the local level. Still others express frustration that this issue, combined with the added complexity of joint and several liability and no cap, means money is being spent on defending and settling lawsuits that could be better spent on serving children.

Sexual Offender Classification and Community Notification

Requirements for youth classified as sex offenders may heighten community concern, making it more difficult to reintegrate youth into the community.

All fifty states require released sex offenders to register with law enforcement or state agencies, supplying their address and other identifying information to local law enforcement or a state agency upon release. Information maintained on the registry varies by state, with some including only the name, address, and a law enforcement identification number. Other states collect very detailed information, which may include blood samples for DNA identification, employment information, residence history, and vehicle registration numbers. Concurrent with registration laws, all states also use notification processes designed to inform communities about convicted offenders.

In Washington, The State Community Protection Act of 1990 established registration and community notification requirements for released sex offenders. The classifications rate offenders based on their potential danger to the community. Level I offenders are judged to be at low risk to reoffend, often first time offenders with no other criminal history. Level II usually have more than one conviction and are considered moderate risk to reoffend. Level III are higher risk, having a history of sex offenses and/or probation or parole violations.

The Act authorizes law enforcement to release "relevant and necessary" information about convicted sex offenders to the public. Notification of placement of sex offenders is authorized “when the [local law enforcement] agency determines that disclosure of the information is relevant and necessary to protect the public and counteract the danger created by the particular offender.” RCW 4.24.550(1).

Notification goes to specific categories of recipients (e.g. schools, day care centers, victims and witnesses) depending on an offender's level of risk. Published notification or news release is mandatory for Level III sex offenders. RCW 4.24.550(4). Notice typically includes offender's photograph (per policy of the Washington Association of Sheriffs and Police Chiefs).

For juveniles, "at the earliest possible date, and in no event later than thirty days before discharge, parole, or any other authorized leave or release, or before transfer to a community residential facility, the secretary shall send written notice of the discharge, parole, authorized leave or release, or transfer of a juvenile found to have committed a violent offense, a sex offense, or stalking, to" the local chief of police, sheriff, schools and others. RCW 13.40.215.

In 2001, JRA released approximately 252 Juvenile sex offenders. DSHS was unable to place 10 or so, requiring DSHS to look for emergency options such as out of state placements.

Some interviewees express concern that as sheriffs widely publish information about offenders returning to the community, including name, picture and location where they will be living, youth are stigmatized or 'demonized', the community becomes overly concerned, and placement in a residence in that community becomes difficult if not impossible. Other local options often don't exist, say interviewees, because communities are increasingly unwilling to allow agencies to site housing for this population.

This is described as a particularly challenging issue for Level II and Level III sex offenders who are between ages 18 and 21. Only minimal resources are available for transitional housing and even at that, there are few places willing to provide housing for such individuals. These youth need appropriate housing, appropriate independent living skills instruction, and assistance in structuring their environment for successful reentry. Registration requirements and the community reaction often mean that the path of least resistance for youth is to register as homeless and make night to night arrangements for shelter. This complicates their ability to secure employment which further complicates their housing stability and successful reentry. Such transitory arrangements then present other community safety issues.

Others express the view that the public safety benefits of community notification far outweigh the difficulties it causes.

Local zoning regulations

Local land use policies and zoning regulations have created a barrier to providing sufficient housing and treatment services in some communities, but under *Olmstead*, DSHS is required to provide certain housing and services in the community.

While the State can override municipal zoning laws for limited purposes (prisons; also, the Legislature recently added statutory authority with regard to adult sex offenders), the siting of other facilities is subject to local law.[40]

Pursuant to regulations established by the Department of Justice, states must provide certain services in the most integrated setting appropriate to the needs of qualified individuals with a disability. Under a 1999 U.S. Supreme Court decision, *Olmstead v. L.C.*, 527 U.S. 581, 144 L.Ed.2d 540, 587,119 S.Ct. 2176 (1999), the Court ruled that the Americans with Disabilities Act may require states to provide community-based services rather than institutional placements for individuals with disabilities, taking into account the financial capacity of the state and other demands on resources, when such services are clinically appropriate.

The shortage of community-based housing and treatment facilities across the state, combined with local zoning decisions aimed at keeping various types of housing and facilities from being sited, creates a difficult challenge.

Administrators, program managers and providers all speak to a growing concern that in their view more and more local governments are making it so difficult and expensive to site a new facility, even something as small as a group home, that no new services are coming on line. This is seen as especially problematic for those in need of housing who are not readily welcomed in many communities, such as sex offenders and those with significant mental illnesses.

There are, however, both State and Federal Laws which constrain local control.

The state's Growth Management Act requires local jurisdictions to include provisions in their land use plans for "essential public facilities". RCW 36.70A.200. (1) . . . Essential public facilities include those facilities that are typically difficult to site, such as . . . state and local correctional facilities, in-patient facilities including substance abuse facilities, mental health facilities, group homes, and secure community transition facilities as defined in RCW 71.09.020.

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40 AGO 1992 No. 25, concluding that "adult family home[s] shall be considered a residential use of property for zoning and public and private utility rate purposes. Adult family homes shall be a permitted use in all areas zoned for residential or commercial purposes, including areas zoned for single family dwellings."

The key federal law is the Fair Housing Act ("the Act"), which prohibits discrimination in the application of local zoning laws for people with disabilities. The Fair Housing Act prohibits a broad range of practices that discriminate against individuals on the basis of race, color, religion, sex, national origin, familial status and disability.[41] The Act does not pre-empt local zoning laws. However, the Act applies to municipalities and other local government entities and prohibits them from making zoning or land use decisions or implementing land use policies that exclude or otherwise discriminate against protected persons, including individuals with disabilities.

The Fair Housing Act makes it unlawful:

- To utilize land use policies or actions that treat groups of persons with disabilities less favorably than groups of non-disabled persons. An example would be an ordinance prohibiting housing for persons with disabilities or a specific type of disability, such as mental illness, from locating in a particular area, while allowing other groups of unrelated individuals to live together in that area.
- To take action against, or deny a permit, for a home because of the disability of individuals who live or would live there. An example would be denying a building permit for a home because it was intended to provide housing for persons with developmental disabilities.
- To refuse to make reasonable accommodations[42] in land use and zoning policies and procedures where such accommodations may be necessary to afford persons or groups of persons with disabilities an equal opportunity to use and enjoy housing.

However, the disability discrimination provisions of the Fair Housing Act do <u>not</u> extend to persons who claim to be disabled solely on the basis of having been adjudicated a juvenile delinquent, having a criminal record, or being a sex offender. Further, the Fair Housing Act does not protect persons who currently use illegal drugs, persons who have been convicted of the manufacture or sale of

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41 The Fair Housing Act uses the term "handicap." This document uses the term "disability" which has exactly the same legal meaning.

42 What constitutes a reasonable accommodation is a case-by-case determination. Not all requested modifications of rules or policies are reasonable. If a requested modification imposes an undue financial or administrative burden on a local government, or if a modification creates a fundamental alteration in a local government's land use and zoning scheme, it is not a "reasonable" accommodation.

illegal drugs, or persons with or without disabilities who present a direct threat to the persons or property of others.

Interviewees expressed a desire to see the State challenge local zoning ordinances that may be in conflict with the Fair Housing Act.

Others speak to the futility of having to go through all of the local processes in order to be denied and then suing under the Fair Housing Act.

Others voiced the opinion that providing community-based housing and treatment for individuals not protected by the Act will continue to be challenging unless state legislation is passed modifying local authority, as was recently done with adult sex offenders.

V. PERSPECTIVES AND RECOMMENDATIONS

This section contains a synthesis of information gathered from more than 150 key informant interviews with a wide variety of professionals who work with 'hard to place youth' at all levels of multiple systems; foster and biological parents of 'hard to place' youth; youth who are or were considered to be 'hard to place'; policymakers; researchers; advocates and professional associations.

Among those agencies and program providers interviewed were residential treatment centers, group homes, state foster care programs, treatment foster care programs, juvenile justice programs, multisystemic therapy programs, sexual offender treatment programs, family support programs, research centers, national coalitions and associations, and juvenile justice agencies.

In addition to these interviews, the Committee heard panel testimony, case study presentations and received input via the internet. These too are included in this summary of perspectives. While the various avenues for input yielded a wide range of views, the concerns and recommendations reviewed here were frequently, in some cases universally, articulated.

Values

Of critical importance to many interviewees across the state is the need for DSHS to implement improvements to the overall foster care system[43]. Interviewees stressed the value of DSHS following through on these system-wide recommendations as a way to better meet the needs of <u>all</u> youth, including 'hard to place'. By improving the system as a whole, fewer children will languish in the system, becoming 'hard to place adolescents' due to lack of support, services or permanency options being provided. This will reduce the number of 'hard to place' youth to those who truly have extraordinary medical, behavioral and mental health needs.

Interviewees would like to see a model of service delivery where:

> Services are individualized, family-centered, strength-based (as opposed to pathologically-oriented) and culturally competent. They would be managed in a collaborative way at the community level. The system of care would be organized as a coordinated network driven by the needs of the adolescents and their families, with families as partners in the decision-making and service provision.

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[43] Many of these improvements to the foster care system have also been recommended by previous task forces, Washington State Institute for Public Policy reports and various collaborative initiatives such as the Families for Kids Partnership. Interviewees express a strong desire to see more progress made in implementing these suggestions.

As well, by focusing attention on the entire system, consistent vision, principles and values drive behavior throughout the organization and all families are better served. Interviewees would like to see an organizational culture created where the values of all those working in the system are consistent no matter what role they play.

Values should include:

- Do whatever it takes to have healthy children and families.
- We will serve kids from our area in our area, and in a culturally appropriate way.
- Families play a critical role as partners and should be viewed as such.
- Placement should allow children to stay connected with family and community.
- Regional, community-based collaborative efforts are preferred.
- Liability concerns are important, but should not override good policy & practice.
- The needs of kids and families should drive budgets and systems, not the other way around.
- Policy and funding decisions should then drive implementation of best practices.

Interviewees were also consistent in their views that parents – both biological and foster - should have more involvement and support. Parents want to be considered as partners in a team approach to meeting the needs of the youth in their care, not as adversaries to be "blamed" for the behaviors at issue.

The top priority for all parents interviewed is for respite care to be provided as needed, rather than rationed because of assumptions that it will be "abused". Parents express the need for more effective services, training and support in dealing with children who have medical, emotional or behavioral disorders.

Parents and youth both describe a need for easier access to services, particularly when they have to deal with so many different needs. Parents feel that there are not enough mental health resources for children – particularly when inpatient care is required, and that requests for services or treatment are often delayed significantly.

There are a significant number of parents who describe wanting help, but not being able to receive services until a child's behavior reaches crisis levels. By that point, the escalating behavior problems make housing and treatment more difficult to access and more expensive to provide. To many, it feels like the only early intervention revolves around taking children away rather than helping parents who are struggling to find the services and support they need.

> "If I could have had the programs and support that are offered to foster parents, I never would have had to give up my daughter. I just didn't know what to do to deal with her behavior and it was getting worse and worse. She became one of your 'hard to place' kids."

> "Caseload size and funding cuts lead us to behave as an agency of last resort, with the view that we simply do not have the capacity to do voluntary engagement with families when they ask for help."

Foster parents feel that decisions are often made on behalf of the children in their care, without their input or knowledge. They are seldom included in the mental health treatment plan for the child and have less frequent contact with the case worker than they would like.

Foster and respite care parents describe a concern that they are often not provided full information about a foster child's diagnoses and behaviors, so are unable to effectively handle the behaviors when they arise, which results in the placement being seen as a failure and the child being moved.

Foster parents would value being connected to mentors who have been foster parents, as they have to learn the ropes of getting licensed and the challenges of being new foster parents.

RECOMMENDATIONS

> "We are trying to meet the needs of youth who have significant emotional and behavioral disturbances, some of whom the community views as a danger to the public, in a system designed many years ago to care for dependent children. These are problems that the foster care system for dependent children was never designed to address."

SERVICE REFORMS

1. **Eliminate long-standing assumptions about 'hard to place' youth and their families, as described above.** ***(See Section III. Promising Practices & Model Programs).*** **These assumptions or practice biases lead to an emphasis on the need for a facility or facilities rather than re-thinking the nature of services and how and where they are delivered.**

2. **Replicate, expand and sustain collaborative, community-based approaches that are already working well in some regions of the state**

and be open to adapting promising practices from other states that can work locally.

"We have some critical building blocks in place, and some regions have made the shift, but the rest of the state is at a fork in the road. If the Committee recommends 'bricks and mortar' or traditional approaches rather than taking advantage of their clout to help move us in the direction that is already showing good results, we'll be on the wrong path for a long time."

A. Ask those regional administrators and RSN directors with the most success to date in implementing the approaches outlined in this report to lead an effort to help all regions move in this direction.

B. Provide each region with a format to evaluate their current array of services, processes, policies & procedures against the ideal system to describe the existing continuum, gaps, identify strengths, weaknesses, connections & opportunities for reform. Use a tool to "cross walk" between ideal and existing for each key element of the system.

C. Partner administrators and managers from those regions with promising practices underway with others to help facilitate needed practice changes across all regions. Consider rotating staff to help "seed" new approaches.

3. **Use the earliest contact points as intervention opportunities for screening, assessment and early referral/treatment for families, providing a different response for those families requesting support and access to services than for those families where abuse, neglect or abandonment is at issue. Policies and training should clearly speak to differential interventions from the point of initial contact with DSHS.**

Looking at the service histories, the first contact with DSHS for many families is often the Economic Services Administration –for welfare or food stamps or temporary assistance. Families also have contact through the First Steps program for very young children. Schools provide an additional early intervention point.[44]

An assessment approach such as the Minnesota Alternate Response model of intervention for low-risk child protection cases utilizes a family assessment

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[44] The Children's Administration currently has a small pilot project in the Smokey Point office that employs a school-based family assessment intervention model for low-risk child protection referrals. The Smokey Point project bases a Child Protective Services social worker in an elementary school as a "school outreach specialist." The outreach specialist meets with families referred as low-risk child protection cases to help determine service needs and connect them with appropriate resources.

response within a dual-track child protection system. It provides greater flexibility than the traditional investigative model and allows the level of intervention to match the level of risk for child abuse or neglect.[45]

4. Use a brief screening tool that leads to immediate provision of integrated services and does not delay intervention, minimizing the varied approaches that might otherwise occur from caseworker to caseworker.

The ability to treat youth in their communities requires adequate assessment of both youth and of the context in which they live their life: their family, their school, and their community. An adequate assessment was described by interviewees as a multifaceted process that includes both an understanding of the behavioral problems of the youth and how these function within the family setting and all the relationships that are a part of the child's home.

One of the earliest studies of foster care decision-making found that although a relationship existed between the degree of disturbance and type of recommended placement, the direction of the relationship and the predictions about a child's placement varied substantially among caseworkers. For example, in a recent study of decision-making by independent Assessment and Care Coordination Teams (ACCT) in Tennessee, researchers found that even with training on the use of decision support tools, case managers based placement and service decisions primarily on the labels applied to children and whether they entered through the child welfare, mental health, or juvenile justice system (Martin, Peters, and Glisson 1998). Recommendations for placement restrictiveness and mental health services were unrelated to the child's psychosocial functioning. (*Berliner and Fine, Children in Long-Term Foster Care in Washington, Washington State Institute for Public Policy, June, 2001*).

A. Train caseworkers how to use the assessment information in treatment and service plans.

B. Share the current screening tool ("Kidscreen") with researchers at Duke, Oregon Social Learning Center, Washington State Institute for Public Policy and others with expertise in risk and protective factors to add this element to the existing checklist. [46]

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[45] The benefits of an alternative response are: safety through family engagement; more effective use of resources; minimization of the confrontational experience; enhanced cooperation; strengthened ability of the family to take care of itself.

[46] A strong, broad, and rapidly expanding research base now exists that pinpoints family-level antecedents, risk, and protective factors that are directly involved in the early development of children and can lead to substance use, conduct problems, risky sexual activities, and other related problems in adolescence. The influence of family factors begins at birth or before and continues through early and middle childhood into adolescence. Increasingly, this developmental research base has been used to inform the design of preventive and clinical interventions that are

C. Include in each assessment information regarding strengths, capacities and youth/family preferences in addition to risk and protective factors.

D. Note in each assessment services or supports that were helpful in the past, as well as those that were not helpful.

5. Bring together people from both the dependency and juvenile offender systems[47] to develop procedures to disseminate assessments, allowing everyone involved with a child access to current, accurate information, while not violating confidentiality or exposing youth to potential legal consequences for participating fully in the assessment process.

6. If the assessment indicates a youth and family with complex needs and/or multiple system involvement, put him or her directly on a "complex needs track" with a single case manager and services provided in an integrated way, instead of multiple case managers with services provided in a sequential manner, where the youth is required to "fail" at a lower care level before being allowed access to more intensive services.

A. Have a complex needs team in each region to handle these referrals, moving them at the outset to community-based services designed to serve this population, rather than expending resources by starting with family reconciliation or other services not designed to provide the intensity of services needed.

B. Provide additional cross-training for staff in each region, to help clarify roles, responsibilities, collaborative expectations and available services.

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specifically focused on helping families deal with a variety of risk factors that emerge from early childhood through middle adolescence. For example, risk factors identified with juvenile crime include failure in school, family problems (history of criminal activity, sexual or physical abuse, neglect, abandonment, lack of parental control over a child), substance abuse (alcohol, other drugs), pattern behaviors (running away, stealing) and conduct problems (not outgrowing aggressiveness by early adolescence), gang membership and gun possession.
John Reid and Mark Eddy, Oregon Social Learning Center, Eugene Oregon. 1996

47 Those developing the protocols should include case workers, juvenile probation officers, providers/evaluators, CASA volunteers, judges, commissioners, assistant attorneys general, prosecutors, and defense counsel representing both dependent and offender youth.

7. Aggressively and uniformly implement permanency strategies from the point of assessment as a basic practice.

"I don't understand why they don't always begin with the basic question of: Who loves this child and how do we get them back in his life? It seems such an obvious place to start."

"There is a family for every child. People assume some kids are too hard and families will be too reluctant, but sufficient support and training, along with an agency that that will stand behind the child does work. We have placed kids who have set fires, who have been sexually aggressive, who have had fetal alcohol syndrome along with severe behavioral disorders and they have thrived!"

A. Strive for children of every age to have a permanent family, regardless of special challenges or complex family history.

B. Consider every safe and healthy relationship with an adult as having the potential for being a lifelong connection, don't look only for those who are willing or able to be full-time parents and reject the others out of hand.

C. Use specialized teams in each region to conduct extended family searches at the earliest point, using computer technology, and a more centralized process to initiate and expedite the searches. Look to the design used by Catholic Community Services, Casey, tribes and other successful models.[48]

D. Actively involve youth in the development of their own permanency plan. They often know what would work.

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[48] Family search tools used by some of those having good success are:
Family Ancestry Chart
Internet sites for locating persons
Reverse Directory Search (Telephone/Address)
www.familysearch.org (Mormon Church)
www.geneologytoday.com
www.people-finder.com
Background check sites
www.ussearch.com
Prison Locator Services
International Social Services (Baltimore)
American Red Cross (International Search)
Inter-State Compact for the Placement of Children (ICPC)
Indian Child Welfare Act

E. Modify Family Group Conferencing to focus on clearly established permanency goals[49] and use it as a tool at the front end when initial placement decisions are made.

F. Eliminate the practice of case workers prohibiting providers from looking for families.

G. Allow caseworkers to access child support records that often reflect fathers who still have a continuing interest in their child as indicated by several years of ongoing financial support.

H. Increase use of appropriate kinship care when out-of-home placement is needed.

I. Minimize financial disincentives toward permanency, such as services that are funded for foster parents but not adoptive parents (e.g., childcare, treatment services, independent living services, eligibility for post-high school financial aid).

J. Provide training for case workers to help minimize institutional practices and assumptions about paternal family members, to significantly increase a youth's options for family connections.

K. Provide training for case workers to minimize institutional practices and assumptions that termination of parental rights also severs the rights of grandparents and other relatives, to significantly increase a youth's options for family connections.

L. Provide training for caseworkers so that they have a working knowledge and appreciation of the legal processes and timelines in the State dependency statutes, Indian Child Welfare Act and the Federal Adoption and Safe Families Act.

8. Minimize the frequency of 'crisis placement' by enhancing transition planning, targeting solutions for those transitions creating the most crises.

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[49] Interviewees noted the value of Family Group Conferencing in placing a greater emphasis on bringing families together to develop options for youth, but noted that simply bringing families together should not be viewed as an outcome of the approach, rather than outcomes more directly related to permanency. Without the focus on permanency, FGC could have the unintended consequence of leading to more 'placements', not permanency. As well, it can be devastating for a child to have his or her extended family gathered to make decisions regarding the child's future, only to be told the entire family decided the future is placement ("no one wants you"). Without a focus on permanency, this is another possible unintended consequence.

In assessing when and how youth become 'hard to place', the barriers for a significant subset appear to occur because placement plans are too often developed late in the process and are not adequate in terms of a youth and family's preparation for change. Additionally, placement in group care, foster care or incarceration is viewed by many line staff as a time to be able to focus on other cases, rather than as an opportune time to do extended family searches, family group conferencing, child and family team meetings or other permanency steps to avoid having a 'hard to place' youth at the time of next transition.

> "This kid was sent to several group care places all over the state because they said he was hard to place. Within literally one hour after they called us for help because they had run out of placements, we found family members who wanted him. The family members had been trying to track him down but he had been moved so many times and wasn't allowed to have contact. And you know they were a mile away from one of the group care places he had been in. And, on top of that, they were licensed child care providers!"

> "When a youth is in a JRA facility, overloaded caseworkers see that as "at least he is in a safe place" and instead focus their energies on other kids. But when that youth is ready to be released, we cannot hold on to him even a day longer because of determinate sentencing laws. So all they have done is create another crisis."

A. For youth moving from home or foster care to a group residential facility, an inpatient facility or a juvenile rehabilitation facility, eliminate the practice of essentially 'setting aside the file' at the time of placement until just before release. Exit planning should be part of the treatment plan from the beginning of the placement, and include the family, youth and professional staff of the institution to enhance continuity of connections for the youth, minimize treatment disruption, help the family gain the skills needed to continue behavioral management improvements, and be consistent with permanency planning strategies.

B. If extended family or adult permanency searches and family meetings were not done at the time of initial intervention, use the period of the institutional placement to ensure that these occur as the first strategy to avoid a 'crisis' at time of release.

C. For youth being released from JRA facilities, implement the pending interagency agreement between CA and JRA, defining standardized, comprehensive referral packets, responsibilities and timing standards.

D. Where extended family searches and family permanency meetings do not lead to a timely and appropriate option for youth being released from JRA facilities, build on the "*No Wrong Door*" pilot project between JRA and Children's Administration to identify dependent youth who will be needing placement at the beginning of their residential placement in JRA, utilizing a Multi-Disciplinary Team planning

process to begin transition planning with CA partners in conjunction with local mental health providers, DASA, DD, school, family and other partners.

E. Continue the statewide transition protocol developed to address the issue of Medicaid funding for mental health services being cut off at the time of incarceration. Using this protocol, youth are quickly re-connected to mental health services within 5 days of release from a JRA facility.

F. Analyze fiscally prudent ways to "hold the bed".[50] Caseworkers indicate that a significant barrier to earlier or continuous transition planning is that they cannot keep a bed open either in a foster care or group care setting for more than two weeks without losing federal funding. Thus they are reluctant to engage in planning further ahead than that. They offer the view that if there is a bed somewhere, someone else will take it before their client is released, so there is no point in planning for it. To further exacerbate the problem, if DSHS cannot then find a bed for the youth being released, they will move another youth doing well in that foster home placement in order to find a spot for the 'crisis placement'.

G. Address the issues of youth whose needs do not appear to match those currently in the provider continuum of care by contracting with providers via regional consortiums or alliances, where providers have the freedom to choose among them the agency with the best match in terms of service and population fit.

1. The alliances should have a lead agency coordinate referrals and share the intake process with participating agencies, as a way to overcome the necessity of a new referral, assessment, medication regime, and clinical staff if a youth needs to move from one provider to another.
2. The alliances should develop a small number of short term transition beds (in homes or in a separate area on the grounds of residential treatment centers that have been converted for this purpose) in each region for use as an interim placement resource for those youth with no immediately available options at time of initial intervention and those youth transitioning to

[50] For example, if it is costing DSHS x dollars a month to send a youth out of state, to residential group care or to pay a higher amount to a foster care home due to the urgent nature of the 'crisis placement', then one could calculate the comparative cost of a policy of paying full or pro-rated costs to keep a placement that is most appropriate open for a period of time. This would be especially valuable where the foster family indicated they would take the youth back when released. Some families might be willing to serve as respite providers or mentors during this time as well.

and from short term residential care being provided for stabilization. Prohibit, with no exceptions, the length of stay from exceeding 30 days to avoid concerns about DSHS using these transition beds as 'placement' and youth languishing there. Require that any time spent there include an assessment, family permanency meetings, extensive extended family search and other permanency strategies. Move youth to a more normalized setting as quickly as possible.

9. For youth with complex mental health or behavioral needs, use cognitive behavioral treatment and other interventions that are research-based and shown to be effective in achieving positive outcomes.

Looking at a sample of case files for these youth, a large proportion has mental health needs and anger control problems noted as significant barriers to permanency. The mental health system primarily serves youth in one of two ways: crisis response when episodes requiring hospitalization occur, or 50 minute office visits to clinicians where the child is not viewed in the context of his/her family, school or peers.

Interviewees strongly suggest that the State and RSNs undertake a significant shift in the way mental health services are provided for these youth, so that the primary interventions are not only community-based, but are also preventative and sustained[51], integrated with other services and supports being provided, play a role in assisting the child welfare system in connecting youth with family or other permanent relationships and achieve positive outcomes of healthier children and families.

The usual care (i.e., treatment evolved from clinical practice and supervision and not primarily from research) has very weak effects. Indeed, studies thus far suggest that usual care is, on average, no more helpful than having no treatment." (*Weisz, 2000*)

The research literature, based on studies across several states, suggests that between half and two-thirds of the children entering foster care exhibit behavior or social competency problems warranting mental health services... [This] suggests that the child welfare system and the mental health system may be more strongly

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51 Legislative direction may be needed to make this kind of shift from crisis stabilization to early identification and intervention for serious emotional and behavioral needs. *See: RCW 71.24.035 (5) (b)* ***Secretary's powers and duties as state mental health authority, county authority.*** *"Assure that any regional or county community mental health program provides access to treatment for the county's residents in the following order of priority: (i) The acutely mentally ill; (ii) chronically mentally ill adults and severely emotionally disturbed children; and (iii) the seriously disturbed."*

linked than commonly thought…more explicit, collaborative ties need to be forged…" *(Landsverk and Garland, 1998)*

The most common factor associated with placement disruption is the presence of serious emotional and behavioral problems that impair children's functioning. (*Berliner and Fine, 2001*) It becomes difficult to differentiate whether the behavior first impacted the placements, or separation from family and resulting placements impacted the child's behavior and emotional stability.[52] Either way, Child Welfare and Mental Health must work closely together to address the resulting needs.

Too often, children are not identified as having mental health problems and those who do not receive services end up in jail. Children and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources. (*Surgeon General's Report on Children's Mental Health, 2000)*

> "The issues these kids have don't fit the diagnostic categories the mental health system uses so we can't get services unless we classify them as depressed, bi-polar or schizophrenic or until they harm themselves or someone else – it's no wonder they are having a hard time serving them at that point."

A. Ask those RSN directors using evidence-based practices, partnering with the Washington Community Mental Health Council, to lead statewide reform in the clinical practice for these youth. A paradigm shift is needed so that the practice model is evidence-based and outcome-driven, including approaches such as wraparound, multisystemic therapy, intensive case management, and therapeutic foster care.

B. Convene the RSN Administrators' coordinating body jointly with DSHS leadership and other key players to design a collaborative way to shift the practice for this population.

C. Establish best practices.

D. Provide practice guidelines, clinical protocol manuals, regulations, fidelity measures, quality monitoring and training.

E. Work with local universities to have community practice curriculum.

F. Tie money and regulations to cognitive behavioral therapy and other approaches shown to be effective when working with this population of adolescents with severe behavioral issues.

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[52] Placement disruption is often linked to a lack of respite or lack of support for the foster family that has been dealing with the behavioral issues that arise.

G. Encourage RSN leadership from Pierce, Clark, Chelan-Douglas and others who have re-oriented their services to partner with RSNs and regions using more traditional practice approaches.

H. Expand the use of MST and explore expansion of other programs JRA and juvenile courts have been providing to youth in their care that are having proven success –Family Functional Therapy, Aggression Replacement Training and Dialectical Behavioral Therapy –to youth outside of the JRA system.[53]

I. Explore whether "grave disability" as defined or interpreted with regard to involuntary treatment of 13 – 18 year olds needs to be modified.

As discussed in Section IV above, the age of consent for mental health treatment in Washington state is 13, meaning that a youth age 13 or older can refuse such treatment. For involuntary treatment, there must be a commitment hearing, and a youth must be found to have a mental disorder (RCW 71.34.020(13)) and present as either gravely disabled or at likelihood of serious harm (RCW 71.34.020(11)). Gravely disabled minor means "*a minor who, as a result of a mental disorder, is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his health or safety.*" RCW 71.34.020 (8) These are essentially the same definitions used for adults in mental health proceedings (71.05.020(14), (19) and (2)).

The concern expressed by providers and parents is that these definitions are not workable as they are applied to teens and that it is sometimes very difficult to get County Designated Mental Health Professionals ("CDMHPs") to intervene with a youth until it is an acute crisis. While there may be some cases where a teen rapidly decompensates to get to the point where the definitions apply (maybe a case of a sudden onset of schizophrenia), generally speaking it takes some time and perhaps a lot conflict within the family or the community before most youth reach the point where these definitions become operable. Given that youth are more vulnerable than adults, consideration should be given to having a broader

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53 **Functional Family Therapy (FFT)** is a 12-week family treatment program that has shown significant reductions in delinquency, violence, and substance abuse of at-risk youth.

Aggression Replacement Training (ART) is a cognitive-behavioral group intervention program that focuses on skills building, moral reasoning, and anger management.

Multi-Systemic Therapy (MST) is a nationally recognized family and community-based treatment program targeting juvenile offenders who have been assessed as the highest risk to re-offend.

definition of what constitutes behavior that places someone at the point of risk or potential harm.

10. Require providers who serve this population to have '24-7' crisis response capability.

"These services are supposed to help, but they expect me to be able to schedule my child's crisis on Monday through Friday from 9am to 5pm."

11. Encourage Courts to assume a leadership role in the overall dependency system and to adjust their processes to achieve permanency within the mandated State and Federal timelines.

A. Expand the Unified Family Court Model to more courts, treating families within a therapeutic context that emphasizes the families' capacity to improve the quality of life for all family members.

B. Set judicial standards for court action within mandated timelines that prioritize home-life stability and permanency, including regular and frequent monitoring hearings.

C. Adopt a "one judge, one child", "one child, one social worker", "one child, one attorney" approach so that there is a consistent and knowledgeable team involved in decision-making with regard to permanency and treatment for the youth and family throughout the life of the case.[54]

D. Allow youth to be present and have input at hearings, where appropriate.

E. Allow service providers (i.e. private agency staff) to be present and give input during court proceedings when appropriate. Generally only the Guardian Ad Litem ("GAL") is allowed to give input during court proceedings, and he or she may believe out-of-home placement is the only option.

F. When alternative family placement is need, seek to utilize youth's ideas, even though those individuals may not be licensed, by use of a "motion for suitable person".

G. Provide judges, commissioners and GAL with information and training about community treatment for youth with severe emotional and behavioral disorders to minimize assumptions that more restrictive settings are the only or best alternative for these youth and families.

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[54] Interviewees also suggested having a single case worker for siblings whenever possible.

H. Open dependency proceedings to allow extended family participation.

I. Make sure all case workers understand the legal timelines within which they must operate and the significance of key dates and court hearings to their clients.

12. Link families and foster homes with residential treatment providers in a hub and spokes approach, so that clinical staff and other service providers can continue working with youth who were in their care, providing necessary support and enhancing the likelihood of ongoing stabilization after transition from the group to home setting.

13. Encourage accreditation of service providers to help ensure use of best practices and provide greater accountability.[55]

14. Work with the Legislature to revisit the legislation capping funding for services and support to those families with developmentally disabled youth in need of intensive services.

In 1998, the legislature created the Voluntary Placement Program (VPP) in RCW 74.13.350, while eliminating Children's Administration's (CA) ability to place developmentally disabled children in foster care under "D-dependencies." "D-dependencies" provided a mechanism for families to have out-of-home long-term care for their child without a finding of neglect or abuse; however, families had to relinquish custody of their child.

In the VPP, youth with developmental disabilities who are under 18 years of age may, in certain circumstances, be eligible for out-of-home placement in licensed foster care settings and support services. The birth/adoptive parents retain custody of the child and participate in shared parenting with foster care providers. Administration of the VPP was assigned to the Division of Developmental Disabilities (DDD).

The budget provided by the legislature does not allow for growth in VPP. In June 2001, the legislature determined that the VPP should not be considered an entitlement program and removed it from the Caseload Forecast. Movement out of the VPP is minimal. As youths exit the program at age 21, their service dollars must follow them to pay for adult services. An estimated three or four slots, at most, become available each year. The waiting list for access to VPP services

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55 Accreditation emphasizes a commitment to quality assurance and ongoing quality improvement, but could prove cost prohibitive for smaller agencies.

currently numbers 60.[56]

> "It used to be that families had to give up their kids to get them services (make them dependents of the State). They fixed that, but then capped the number who could get those services. Now all we have is a waiting list. Since folks with severe DD needs tend to need those services for life, no one will ever move up off the waiting list unless someone dies or leaves the state. Now we have to say that our kids are mentally ill in order to get them any kind of services. Some solution."[57]

> "In our County, 62% of the youth we are sending to CLIP beds, 42.5% of those psychiatrically hospitalized, and 30% of the youth admitted to the Adolescent Treatment Unit, have developmental disabilities. They are flooding these costly and limited mental health beds because there are no longer any resources for developmental disabilities services for families. We are seeing huge increases in calls for mental health crisis assistance by families with developmental disabled youth. Then there are no options to help other than inpatient beds designed for mental health services or just sending them back home."

15. Develop capacity in each region for independent or assisted living supports for youth 18–21 years old, who are very low functioning in terms of their cognitive abilities, but are above the cut-off for receiving Developmental Disability services.

Service providers describe a significant gap in the continuum of care for low functioning youth (just above the level of functioning that would allow them to receive developmental disability services). These youth, as they turn 18, find themselves with no long term resource or assistance to help with housing and services, thus often ending up on the streets and vulnerable.

INTERNAL SYSTEMS REFORMS

16. Improve collaboration across the management of DSHS administrations, between DSHS and providers, and among all child-serving agencies to provide more comprehensive and family-centered services.

> "It is unfathomable to me that people in leadership positions say their division won't step up to help because 'he is not our kid'; they are <u>all</u> our kids. These kids bounce from one service system to another. We act as if *they* need to figure out how to

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56 Children's Administration and DDD have in place a protocol for responding to VPP requests. DDD and CA jointly review priorities in the following order of consideration, recognizing that, at any given time, there might be good reason to deviate from this order: currently served by DCFS (since 10/30/01) due to funding constraints of VPP; on the VPP database awaiting out-of-home placements; between the ages of 18 - 21 who remain in DCFS foster care; and in stable dependency guardianships who remain with DCFS.

change to serve *our* interests rather than us needing to change to better serve them."

"Each division develops ad-hoc individual approaches, with treatment starting all over again with each different placement or system interaction, often losing the work, expertise, and knowledge base acquired by each part of the system related to that adolescent. We need the client at the center of the planning approach, not the system".

A. Administrators should model collaborative, cross-system action by the way in which they take responsibility for all children needing services, set goals, measure outcomes, develop performance measures, share information, make decisions, allocate funding and write contracts.

B. Administrators should make the changes needed to replicate at their level the successful collaborative work between CA, DD, MH, JRA, RSNs, schools and communities occurring at the local level in some parts of the state.

C. Children's Administration and the Mental Health Division need to be working hand in hand along with the Regional Support Networks ("RSNs"), with shared values, approach to services and outcomes.

D. Concerns about liability should not strangle opportunities for creative collaboration in the regions.

17. Tie funding allocations used for this population to achievement of proven and cost effective outcomes, community-based services and cross-system collaboration.

"The service system will follow available funding. If they want system change, that's the place to start."

A. Modify the rate structure to allow for more expensive services to take place in the home and to support increasing professional services in family settings, rather than having enhanced services tied to more restrictive settings.

B. Participate in national efforts to reform Title IV-E[58] funding to create incentives for approaches showing positive outcomes, promoting

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58 The principal sources of federal funds for child welfare services are Titles IV-B and IV-E of the Social Security Act. Title IV-B is a capped allocation to states that provides funding to prevent out-of-home placements, for reunification services and for other family preservation and community-based family-support programs, as well as funding for post-adoption support services. Title IV-E is the largest funding source. It consists of foster care and adoption assistance programs, which are both open ended entitlements and the independent living program for older youth (As part of the Foster Care Independence Act of 1999, this was renamed the Chafee Foster Care Independence Program), which is a capped entitlement.

permanency, development and well-being. Explore the viability of using Title IV-E federal foster care dollars to subsidize relative guardians (through the waiver process). Work in tandem with national associations at the State, County and City levels.

C. Include redesign of Title IV-E in the State's Federal legislative lobbying efforts.

D. Link State funding to outcomes that keep children out of the system by expediting permanency or providing services that keep children in their communities and with their families.

E. Ask WSIPP or another entity to conduct regular evaluations of fiscal efficiencies achieved through decreases in use of more intensive and expensive services such as hospitalization, incarceration and group care by utilizing community-based, preventative approaches.

F. Reward community and regional efforts that are improving outcomes through community-based, braided or blended, collaborative approaches by allowing them to retain savings to re-invest in additional system improvements; at the very least, remove the disincentives.

G. Use TANF funds to support family group conferencing as is done in Michigan.

H. Maximize use of federal waivers under Title IV-E to incorporate changes to permanency options that offer relatives and foster parents the option of becoming legal guardians while continuing to receive some form of payment.

I. Develop bi-ennial budgets with as much cross-division interaction as possible and assess any proposed funding cuts in the same way, particular with regard to impact on outcomes.

18. Develop DSHS information systems that provide information centered on the family or youth, in addition to the service or division.

A. Develop an enhanced ability to share information between systems and databases.

B. Develop cross-administration screening/eligibility tools.

C. Develop a common demographic face sheet.

D. Develop a common form for authorizing release of information.

E. Develop a data base of this population that is consistent across all divisions, including information about age, gender, race, diagnosis, region or County, years in the system, cost of service, types of service provided, family members contacted, age at entry into the system, number of placements and type of placements.

F. Develop tracking systems for key strategies in each region to help in measuring performance.

19. Adopt performance-based contracting approaches focused on outcomes for this population.

A. Expand the Community Juvenile Accountability Act ("CJAA")[59] approach used in JRA to other divisions. The CJAA requires that JRA only fund treatment programs that have proven results, evaluated for outcomes and cost effectiveness on a regular basis by the Washington State Institute for Public Policy ("WSIPP").

B. Re-structure of the payment system for providers to improve efforts to aggressively move children to permanency. Allow agencies to use improved performance in moving children to permanent homes as a way to lower their caseloads and enhance their program. Service providers would no longer be reimbursed by caseload count, but on the basis of permanent placements.[60]

C. Create performance incentives for case workers and managers that are aligned with preferred outcomes (e.g., for each youth where expedited permanency is achieved, another case will not be added to a caseload for 3 months.)

D. Stop funding programs and approaches that are not showing outcomes, especially where cost is greater than those that are showing outcomes.

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59 **The Community Juvenile Accountability Act (CJAA),** passed in 1997**,** is described as the first attempt in the nation to implement research-proven, cost effective intervention programs for juvenile offenders on a statewide basis. The law calls for a coordinated effort between state and local entities.

60 For example, Michigan and Illinois have created a way that agencies accept a percentage of their caseloads in new referrals at the same time they are also required to move the same percentage of their caseloads to permanency. Those who moved more than that percent to permanency secure caseload reductions without a loss of revenue or pay. Failing to meet the benchmark means serving more children at the same contract level, and then lowering the contract level by stopping the assignment of new referrals.

20. Strive to minimize turnover and maintain a highly skilled workforce in DSHS, by making caseload size and pay consistent with national standards, with caseload size decreasing as level of complexity of clients increases.

21. Have DSHS licensing staff include customer service strategies as part of their role, in addition to their role in promoting safety.

A. Continue quality initiatives redesigning the foster home licensing process to provide more 'customer support', assisting new applicants in understanding procedures, overcoming barriers and reducing time to get licensed.

B. Partner existing providers with new applicants to help them through the licensing process.

C. Provide a "one stop shopping" approach for providers who currently have to get licensed by multiple agencies for each treatment modality (e.g., substance abuse, mental health, developmental disability) they provide.

21. Create a liability fund to cover increased insurance costs and deductibles required by State statute, as a way to help parents and providers who are reluctant to take 'hard to place' youth due to behaviors such as fire-setting which may result in property damage or lawsuits.

RCW 74.13.335 allows DSHS to reimburse foster parents for property damaged or destroyed by foster children placed in their care. If the damaged or destroyed property is covered and reimbursed under an insurance policy, foster parents may only be reimbursed for the amount of the deductible associated with the insurance claim, up to the limit per occurrence as established by the Department.

Although the State provides defense for licensed foster parents who are sued "arising from the good faith provision of foster care services", RCW 4.92.060, foster parents remain liable for any damages awarded specifically against them. RCW 74.14B.080 allows DSHS to provide liability insurance to licensed foster parents. The coverage is for personal injury and property damage caused by foster parents or foster children that occurred while the children were in foster care. It is only allowed up to the amount which the claim exceeds the parents liability insurance coverage. For both types, DSHS establishes by rule a maximum amount that may be reimbursed for each occurrence. The maximum currently is $25,000 per occurrence. WAC 388-25-0315.

Liability of licensed foster parents "for the care and supervision of foster children [is] the same as [that] of biological and adoptive parents for the care and supervision of their children". RCW 4.24.590. And under Washington law, "parents are liable to third parties for the tortious conduct of a child if they know of the child's dangerous proclivity and fail to take reasonable measures to control that proclivity." *Carey v. Reeves* 56 Wn.App. 18, 22, 781 P.2d 904 (1989).

22. Explore the benefits and costs of sexual offender notification laws and practices for 12 – 17 year old youth.

A. Explore whether different notification procedures for minors than for adult sexual offenders could create fewer barriers to reintegrating these youth into the community while still providing the same level of community safety.

B. Examine the unintended consequence of having to move victims where the victim and offender are from the same family or neighborhood, and thus are not allowed to have contact, but no other housing option for the offender can be found.

C. Improve current collaborative efforts between JRA and local law enforcement personnel that allow for mutual classification decisions to be made prior to the youth leaving a JRA facility to avoid the problem of JRA determining one classification and the local sheriff another.[61]

D. Survey other states to see what strategies of community notification and education prove helpful in sharing information while minimizing anxiety and concern when youth are reintegrated into a community.

E. Law enforcement personnel should use the guidelines in the Washington State Model Policy for Community Notification, to help with consistency in approach from county to county.

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61 Juvenile end of sentence review committee is a multi-agency committee comprised of JRA, Department of Corrections, victim, witness, local law enforcement, and developmental disabilities staff designed to jointly determine the classification level. The local law enforcement may or may not follow the leveling done by the committee. In the end, local law enforcement makes the final decision.

APPENDICES

Appendix A
'Billy' & 'Johnny' Interview Summaries

Perhaps the clearest way to describe why traditional practices sometimes lead to youth becoming 'hard to place' is by example. Johnny and Billy[62] are two young boys viewed by many people over a number of years as 'hard to place'. Both are approaching age 18, were in the system for years with multiple placements and now currently reside with their families.

Johnny was placed in foster care at a young age when his mother, who has significant mental illness and drug addiction, was unable to care for him. He was ejected from one foster home after another for assault, significant property destruction, and other behavioral problems. He was then sent to the Child Study & Treatment Center ("CSTC"), the state's most restrictive setting for children with profound mental health problems, on the campus of Western State Hospital[63]. He remained there for about six years.

During this time, he became increasingly violent, and was restrained several times a day. Occasionally, he bounced into the juvenile justice system for assaults. His CSTC staff, mental health therapist, DCFS social worker, probation officer and Guardian Ad Litem felt strongly that he could never return to foster care, should have no family contact, and in fact, needed a "more secure setting" than CSTC for community safety. Johnny was considered very 'hard to place' by all those who worked with him.

As he neared age 15, the professionals assessed what his options would be when he aged out of CSTC. Their view was that when he turned 18 he would meet criteria for commitment to Western State Hospital and move straight from CSTC to an adult unit at Western.

From the beginning, Johnny was clear that what he wanted was to be placed with his Grandma. She had been the one to take care of him when he was younger and his mother could not. His case worker and the others on his professional team did not consider his grandmother an appropriate resource since they understood her to be an alcoholic. They did not want him to have contact with her because whenever she came from New York to visit him, it had obviously distressed him. When asked what "distressed" looked like, they described it as Johnny sitting on his bed and crying every day for weeks after she left. They decided her visit caused depression and she should not return.

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62 All names in this report have been changed to preserve the confidentiality of the youth and their families.

63 CSTC also serves children with significant needs arising from physical and mental disabilities or chemical dependency.

The RSN that provided mental health services in Johnny's community decided that after six years in an institution he was clearly not getting better. They asked a private provider to consider providing intensive "wraparound" services with the desirable outcome being that he would live in a community. They worried that after so many years in an institution he might not be able to adjust to living in a community or with a family again.

The provider found a foster home in their network willing to take Johnny while longer term reunification with his family was attempted. Johnny is now living with his Grandma, who was willing to relocate from New York to be with him. The provider helped them find an apartment; connected Johnny to community-based services and even made arrangements to get the grandmother's pets from New York so that she could stay for as long as Johnny needed her.

While acknowledging that Johnny is sometimes difficult to live with, his grandmother loves him and is very committed to him. Johnny sees his mother occasionally, rides his bike everywhere, has a 'sometimes' girlfriend and is starting vocational education classes. He wants to get a job working with a landscaping company. He will soon be 18.

Billy is also a 'hard to place' youth. He and his sisters were removed from his mother and placed in foster care when he was age 10. Over the last six years, he has been kicked out of numerous foster homes and group care facilities. He has also been in JRA and, on several occasions, housed in the basement of DCFS offices. Because he is classified as a sex offender, and had been kicked out of outpatient treatment by three different providers, DSHS felt they had completely run out of options. He was in "overflow" care, moved to a different home every night, and in the DCFS office lobby during the days. He was one of the highest cost kids in the region, averaging about $20,000 per month.

DSHS asked a private provider to help find a place for Billy to live. DSHS social workers told the provider not to contact the family because it was "too dysfunctional", and they should not be considered an option. At one point Billy was placed with a group care provider several counties removed from his biological family. He was prohibited by the group care facility from contacting his mother by phone. He had a different social worker than his sisters, and court-ordered twice yearly visits with them were also not permitted.

The provider began contacting relatives and quickly learned that several wanted to help Billy. Family members had lost touch with Billy because of his many moves. They said they were devastated over losing contact with him. The provider contacted the mother. His mother had always wanted Billy and his sisters back and had been trying to reunite with them for six years.

The new case manager read through the files. After talking with the mother she learned that five years ago Billy's assigned social worker told her she could not get

Billy back unless she took a parenting class and a substance abuse assessment. The mother had completed them and sent in the verification. When she was told by the social worker that she would also have to take substance abuse treatment, she had two more assessments, including UAs, to confirm the initial assessment finding that she had no substance abuse problem. When told she had to have a residence large enough for the children, she moved. When she was asked to have her new boyfriend get security clearance, she sent in the paperwork. Despite all this, her files continued to state “non compliance”. Her children remained in the system.

During this time, Billy continued to create many challenges as a ‘hard to place’ adolescent and bounced continually from one placement to another. He continued to act out. He and his sisters continued to run away from placements to be with their mother. Billy, like Johnny, was always clear that he wanted to live with his family. The more contact with his family was prohibited, the more he acted out and the more he ran. He acted out at school, in foster homes, wherever he was ‘placed’. “I was purposely getting expelled so they would call my mom to come get me. I kept doing worse and worse stuff. Once they did call her by mistake and I got to spend the day with her. But she called the social worker to let her know where I was and I had to go back.”

Billy had been at one time an A student with no medical issues. He is now on a multitude of prescription drugs, based on a diagnosis of "Separation Anxiety". His symptoms were described in his file as: decreased appetite, dizziness (due to anxiety), agitation, aggression, and abnormal walk. He says he did not have a primary care doctor during these six years and only received medical care when he went to the emergency room. He also describes being unable to read in school because he needs glasses for depth perception and he could not get them.

Several case workers have now come and gone on Billy’s case. The file continues to state that his family is not an option. At a recent court hearing, the social worker told the mother it would be best for her not to be there since she was still “non compliant”. The mother attended, provided the proof that had been already given over the last five years to various staff, and the judge ordered Billy returned to his mother.

Billy will be 18 later this year. He is completing high school, wants to take community college classes to become a mechanic, and is determined to always live close to his family. He says his number one priority is helping his mom get his sisters back home.

Appendix B
Summaries of Best Practice Programs in Washington State

In Section III of the report selected Washington state promising practices were described, including the King County Blended Funding Project, the FAST and WRAP program in Pierce and Clark Counties and the Chelan-Douglas, Pierce and Clark RSNs. Below is additional information on each.

Each of the RSNs and the King County Blended Funding Project were asked to answer a set of questions to help the Committee with its recommendations.

I. Information describing key elements of best practices in Washington State-King County Blended Funding Project response:

1. Describe your approach to serving complex needs youth and how it is different than what the practice used to be and still is elsewhere in many parts of the state.

   - The Blended Funding Project uses the wrap around approach with strong emphasis on building community and informal supports. The project emphasizes having families create and manage their own plans with the support of project staff. Families and teams, including non-professionals, are trained to meet the needs of the children and the families with both formal and informal supports. The family and team are the decision-makers. They identify needs and develop a plan to meet the needs.
   - The unique piece of Blended Funding is that the dollars that are used for services are all made available to the family and can be used to pay for the services or supports identified in the plan. The dollars are flexible and can be used for formal, informal, non-traditional services or other tangible supports.

2. What did it take to get this new approach started in your community?

   - The planning for the project took over three years and would not have happened without the help of a Robert Wood Johnson grant. There was strong resistance from traditional providers and many system concerns about giving categorical dollars to a "non-system" agency such as the ESD.
   - Concerns about federal funds, WACs and licensing all had to be dealt with. Most were through compromise or adaptations. The concerns that have remained tend to do with meeting system requirements or taking non-traditional approaches.

3. How did you get the resources to get started and the flexible funding you need?

- The resources came from a Memorandum of Agreement between the systems, the RWJ grant, technical assistance and contributions from the Division of Children and Family Services, King County Division of Mental Health, Seattle School District. In the agreement the services to be paid for were identified and the ability to be flexible with funding was accepted.

4. How many youth do you serve and what challenges do they face? (i.e., the skeptics want to know if you are really serving the hardest kids traditionally considered a risk to self, family and/or community –fire-setters, sexually aggressive youth, youth released from JRA facilities, kids with severe emotional and behavioral disorders.)

   - The project was designed to accept children who met the following criteria:

     - 90% of those served must meet Medicaid eligibility requirements.
     - All youth must meet the 3B medical necessity requirements of the mental health system.
     - 90% of those served must be DCFS clients.
     - Each individual child will be assessed for the Project based on the following:
       - The child has a high cost plan, and there have not been positive outcomes or progress toward a less restrictive setting.
       - The child has had multiple placements that have not successfully met goals or specific outcomes.
       - The child has been in the system for more than two years, all planning and interventions have been unsuccessful and return home is not an option.
       - Existing care facilities have difficulty providing services to the child due to endangerment to self or others.
       - The child is referred from the IST as too difficult to fund or to coordinate.

   In practice youth have not met all of these criteria and some have come into the project when they have had long histories of problems without placement but were heading into long term care or hospital. We have had at least 10 youth who have been refused placement in all residential facilities and one who was effectively banned from foster placement.

5. How does the Community feel about these kids being served in the

community? How did you educate the community or change public perception about these kids?

- Generally the community, (neighbors, recreation services etc.) do not want our kids in the community. The feeling is they should be sent somewhere for treatment. They do not see that the community is capable of doing treatment. It is our task in the project to create and build community for families that can support the family in meeting goals.

6. If we are to recommend strategies to sustain, replicate or expand, what are the key elements that you believe must be part of the approach?

- The system needs simplification. The idea that screens are put in to screen people out of service, refer to other systems, or that solutions are decided at the bureaucratic level and not at the child and family level needs to be changed. There need to be areas where funding is looked at differently, requirements are looked at differently, children served by multiple systems are treated under a single set of rules and the legal system is supportive of community-based activities.

7. What do you do when the parents are unable to effectively partner due to such things as substance abuse or sexually offending behavior?

- Parents are always the parents and need to be part of the child's life. If there are legal or safety restrictions they need to be accepted and addressed. In our project we pair parents with other parents, who have similar experiences in their past, to provide support and confront certain types of behavior. Where we have been able to do this, we have had a great deal of success with this approach.

8. What role do schools play?

- Schools are the common ground for most children and the one area of normalized living situation. Children spend 30 hours a week in a school and there are great opportunities for socialization. Where schools are effective they are dedicated to making it work for the student. They can adapt the education program to the child and make changes to meet needs. However, some schools are like the community and look at expelling the child to some place else.

9. What role do you need DSHS to play?

- DSHS should be a support for community placement. They should assure legal protections and structure is in place. If DSHS is to support alternative programs they need to find ways to be comfortable with risk in doing alternative approaches.

10. What are your outcomes for youth, family and system? Re the latter, do you have any cost savings?

- The outcomes below have continued to grow since the project has continued. The costs have reduced by almost another $1800 a month since these outcomes were identified.

Systems Benefits:
- Are relieved of the burden of the most difficult to serve children
- Can spend time with children whose needs are less intense
- Can easily track services and costs
- Can reduce utilization of crisis services

Outcomes:
- Average service cost has decreased $1166 per month per child
- Children have been placed back in the community
- Community school attendance increased from 48% to 84%

Providers Benefits:
- Are a resource to families, instead of responsible for families
- Have reduced system requirements and reduced barriers to access
- Have freedom to provide non-traditional services
- Can share "tough cases"

Outcomes:
- Improved service coordination
- Increased community resources

Children/Families Benefits:
- Have flexible services individually designed to meet needs
- Have a single care manager and care plan vs. multiple plans
- Have comprehensive plans for all areas of family life
- Have control of their own lives

- Have less dependence on systems and more self-determination

Outcomes:

- Families have met their needs and feel empowered
- Families have fewer obstacles to services
- More supports are available – both formal and informal

II. Information describing key elements of best practices in Washington State – Pierce RSN response:

1. Describe your approach to serving complex needs youth and how it is different than what the practice used to be and still is elsewhere in many parts of the state.

- We embrace the theory and some of the technology inherent in the "wraparound" movement. This has included truly engaging parents in the process of identifying needs and developing strategies to meet them; expecting that systems work together at both the administrative and line staff level to make this happen; and promoting creative interventions – tailoring services to needs rather than fitting needs into existing services.
- We maintain an agency with the exclusive mission of providing services to this population that is supported financially by both mental health and DCFS. Other agencies maintain responsibility to meet the needs of the rest of our target populations (a majority of children served) and do on a limited basis provide intensive, creative and flexible services to complex need youth.

2. What did it take to get this new approach started in your community?

- An open, respectful relationship with other child serving systems based on a common set of principles and goals for these youth. This included such basics as: they are all our children and families (we need to work together); family needs must drive the intervention, not system needs; and perhaps most importantly that simply doing more of the same is not the answer.
- A provider agency that had an openness to put practice behind the principles of family driven, flexibility in meeting needs, active partnering, not giving up, etc.
- Providers licensed as both community mental health centers and child placing agencies.

- Strong parent involvement – in Pierce County we funded a parent organization that has kept us honest in promoting the principles cited above.

3. How did you get the resources to get started and the flexible funding you need?

   - Prior to managed care, budgets were developed for each intensive individualized plan and funding negotiated with the systems involved. Under managed care, savings from reduced inpatient utilization (as a direct result of enhanced community support) allowed these services to expand.
   - Managed care allows flexible use of resources. Prior to that, and as a basic issue, is a willingness to permit teams, including families, to determine what is likely to produce the desired results and fund it. This means recognizing indirect costs within a budget at a greater percentage than is traditional (where direct staff costs make up most of the budget). Of course recognition needs to occur at both the funder and provider level.

4. How many youth do you serve and what challenges do they face? (i.e., the skeptics want to know if you are really serving the hardest kids traditionally considered a risk to self, family and/or community – fire-setters, sexually aggressive youth, youth released from JRA facilities, kids with severe emotional and behavioral disorders.)

   - July 2001 – June 2002: 141 youth served through the intensive service program at CCS.
   - 100% met criteria that included at least three of the following: severe mental illness, violent/assaultive, self-harm/acute suicidal behaviors, sexually aggressive, history of fire-setting or significant cognitive impairments.
   - 86% have exhausted and been ejected from multiple placement resources.
   - 91% have histories of suicidal/self-harming behaviors (usually warranting medical attention).
   - 64% entered services with histories of psychiatric hospitalizations (many with multiple hospitalizations).
   - 20% were involved with JRA
   - 31% have sexually aggressive histories.
   - 59% are enrolled in school.

5. How does the Community feel about these kids being served in the community? How did you educate the community or change public perception about these kids?

- Pierce County has been fortunate to not have experienced any great public outcry against any individual child served in the community. This may be in part due to it being a diverse community with a significant institutional presence (Western State Hospital, Child Study and Treatment Center, Madigan Army Medical Center, Rainier School) as well as a history of community involvement through many organizations, e.g., Safe Streets, Communities and Schools, Tacoma-Pierce County Children's Commission, etc.
- Also, as part of our approach in serving children and families in the community, every effort is made to engage the community in the support of the family. This happens through a variety of venues, including schools, churches, community organizations and simply door to door contact.
- The parent organization in Pierce County is also effective in educating the community through their direct involvement with families in communities.

6. If the Committee were to recommend strategies to sustain, replicate or expand, what are the key elements that you believe must be part of the approach?

- A flexible provider willing to work in non-traditional ways and systems supporting them in doing so. This also means a willingness to change course based on lessons learned, which in our experience have come frequently and rapidly.
- Systems committed to working together beyond rhetoric – creating forums to develop solutions to shared problems/needs; clear, consistent expectations from leadership across systems; local flexibility, etc.
- Adequate funding and relief from regulations that inhibit creativity and flexibility. For funding this means recognizing that in the short term, individualized approaches may not show significant cost savings, whereas over time they may be quite significant. With regulatory relief, this population by definition requires a different approach where regulation is often excessive in terms of treating everyone the same.

7. What do you do when the parents are unable to effectively partner due to such things as substance abuse or sexually offending behavior?

- The term "effectively partner" becomes one focus of the intervention. Helping the parent(s) address their own issues, maintaining some positive relationship between them and their child, and not simply giving up. The age of the child is also taken into consideration. Sometimes a parent may have difficulty parenting a very young child (i.e. if the parent has a problem with substance abuse) but will be able to parent an older or adolescent age youth, especially with support from extended family or friends. It's important to separate a true safety (or neglect) issue from the temptation to remove a child from his/her family in order to punish a parent for substance abuse issues, living in poverty, etc.
- Where it is determined legally that a parent-child relationship must be severed, the search for other "family" becomes necessary. Finding relatives and bringing them into the life of the child is the goal.

8. What role do schools play?

   - They partner actively with each child and family team to maximize the educational success of the child. This means nothing different than what has been cited above – being flexible, creative and truly partnering with the family/support system.

9. What role do you need DSHS to play?

   - Promote local flexibility within a clear framework for accountability.
   - Adequately fund mandated services and provide incentives for systems to partner effectively and efficiently.

10. What are your outcomes for youth, family and system? Re the latter, do you have any cost savings?

    - Reduced hospitalizations (only 4 of 141 have experienced a hospitalization following enrollment into the program; approximately 50% had one or more hospital admissions prior to CCS involvement)
    - Reduced long-term residential placements
    - Improved family stability (91% live with immediate family or extended family)
    - Increased school involvement (100% attending)

III. <u>Information describing key elements of best practices in Washington State –</u>

Clark RSN response:

1. Describe your approach to serving complex needs youth and how it is different than what the practice used to be and still is elsewhere in many parts of the state.

    - We have completely redesigned our system of care around the concept of developing a network of individual service components that are organized around how services should be delivered to children and their families. Our system is guided by a set of basic values and operational philosophies giving families an opportunity to make the decisions as to what happens and what they need. No longer do we have a pull down menu of services, we work creatively together through a wraparound process to develop plans that meet their identified needs, individually tailoring interventions to their needs. Bottom line for us, listen to the families, identify their strengths (we all have them) identify what specifically do they need to not have to be dependent on the public system and then figure out a way to give it to them.
    - In our redesign we asked families/youth to assist us in this process and we have a system very different than what existed before. We now have a Crisis Stabilization Program where families can receive services for their child in an emergency (therapeutic foster bed attached), but this can continue for 90 days to truly stabilize the situation for the family, we now have programs that exclusively do wraparound and services all out of clinic, we have multiple agencies that offer services to their families/youth 24 hours a day and we require that 60% all services provided are out in the community/home/school. We have a parent organization, have parent partners, have a respite pool, and a robust flex fund for families and agencies to access.

2. What did it take to get this new approach started in your community?

    - Meeting routinely with other child serving agencies, recognizing that something had to be done and asking the end users what was necessary. We started asking the right people. It was amazing! I think it is difficult to work with other child serving systems because we all do not have the same goals/values for the children we mutually serve. One has to identify some common set of principles which we did and come together monthly with families to continue to work on these. The System of Care Bill was

"birthed" through this process.

- Lots of hard work and a never give up attitude.
- Strong family involvement, as I mentioned we fund a parent training organization, we require through our contracts and new projects that agencies and other sub-recipients hire and train consumers/families to work with them, we have a parent partner pool of trained parents in our system to advocate for others, we fund a strong youth program and a youth house where we promote youth and youth serving programs in Clark County. This is a center point for all positive youth development and prevention activities.

3. How did you get the resources to get started and the flexible funding you need?

- We already had the resources, just re-engineered them and RFP'd for what we heard families want.
- We also wrote and received a federal SAMHSA Grant for development of SOC.
- We have used inpatient savings to develop programs such as our Crisis Stabilization Program.
- We have created a Youth Foundation this year to sustain much of what we are doing generating other funding opportunities for youth.

4. How many youth do you serve and what challenges do they face? (i.e., the skeptics want to know if you are really serving the hardest kids traditionally considered a risk to self, family and/or community – fire-setters, sexually aggressive youth, youth released from JRA facilities, kids with severe emotional and behavioral disorders.)

- We served over 2600 youth last year up to age 18 years of age.
- We dedicated 49% of our mental health resources to youth; the national average is 10%. This is in addition to our grant.
- We served 42 youth in our Crisis Stabilization Program (all kids who basically had "nine toes" in the hospital and were diverted).
- We served 50+ youth/families in our intensive program.
- We served 156 youth in our Connections Project (joint funded by mental health and juvenile justice) (a juvenile justice high utilizers program).
- We currently will serve 45 youth in our Title IV E Clark

County Wraparound Program another blended funded project with Child Welfare.

- We only sent one youth to a residential placement since September 2000 and enjoy the lowest rate of hospitalizations for children in the State, so something we do must be right.
- All of these kids met criteria for severe mental illness, and violent/assaultive behaviors, self-harm/acute suicidal behaviors, sexually aggressive etc.

5. How does the Community feel about these kids being served in the community? How did you educate the community or change public perception about these kids?

- When you actually ask the public and the other child serving system to join you in designing a new system and you share a common mission, it helps then understand what the Surgeon General says about sending your kids to residential is true. Constantly keep them apprised of the positive outcomes we are achieving by keeping our kids in our community.
- Asking them to problem solve with us helps.
- Also, the public meetings we have monthly to educate the community has greatly helped.
- We use data to show what we are doing is helping and of course data always helps other people to understand. We contract with Portland State University to provide data on all kids involved in our system and they routinely come to our Quality Management Meeting and report, our mental health advisory board as well as the public meeting. See link to Portland State.

6. If we are to recommend strategies to sustain, replicate or expand, what are the key elements that you believe must be part of the approach?

- All Child Serving Agencies must work together (Child Welfare, Schools, Mental Health, DD, Substance Abuse, and Juvenile Justice) and find common values to develop a strong system of care. This should start at the State.
- Don't wait for someone else to do it or give you the money to do it.
- Put families in control of the planning and be innovative.
- Strengthen youth/family development
- Implement strengths based prevention and peer education.
- Empower and engage youth and families.

- Develop a continuum of care across all systems.
- Give the people that are doing this more money...that will probably make the others want to.
- Look at all the money we spend across the state on children and families across system, pool it and then design something around best practices and RFP ALL the money....it might make people step up.

7. What do you do when the parents are unable to effectively partner due to such things as substance abuse or sexually offending behavior?

    - We have had many opportunities to serve youth who have been labeled as sex offenders. In the far majority of these situations we have found parents to be very motivated and appreciative to receive our assistance. We find that parents are overwhelmed, and lack resources to help their own youth. Especially in cases when youth are either aging out of foster care and will end up back home by default, or when they are leaving state institutions we have been able to help prepare families and safely transition these youth back into their communities. We gather family resources, create child and family teams and then collaborate with all available professionals to set up clear safety/crisis plans. Communities do not roll out the red carpet to receive these youth back home, but imagine the alternative... these boys returning without such resources or support. We have worked with two such youth recently, one in Kelso and one in Roseburg, OR.
    - We plan programs like “effective parenting classes” which no one who needs it usually goes unless it is mandated. We need to look for the strengths in the parents, maintain any positive relationship they might have with their child, seize the moment of opportunity for engaging a mom to seek substance abuse counseling after you have developed a trust relationship. I have been amazed at how simple this is. Never give up or never blame.
    - Working with DCFS this year, we know that sometimes it is necessary to terminate parental rights, but what we have found is that placing this child in a relative’s home with support is much better than the foster care route. We devote a lot of time assisting DCFS to find suitable relatives for the child.

8. What role do schools play?

- We wish they played more of a role. The Schools are represented on our Community of Care Council. A School Superintendent as well as an Assistant Sup. They meet with us monthly. We have many school projects and fund several wrap around projects that we evaluate annually to prevent youth from more restrictive placements in the school setting.

9. What role do you need DSHS to play?

- Promote accountability through research and best practice across all systems.
- Take more of a leadership role.
- Pool resources. Be the boss.
- Look for Best Practices across the State, duplicate it, and don't just say we can't.
- Provide incentives for us that do it to set examples.

10. What are your outcomes for youth, family and system? Re the latter, do you have any cost savings?

Please refer to www.rri.pdx.edu/ClarkCo for our research for Children's System of Care; you will see general research presentations, our Juvenile Justice project, as well as our School Projects.

- Low Hospitalization rates.
- Only one residential placement in over two years.

Our research in our programs describes that demand is less when you support families thereby creating a savings in the public system. This defends our Parent Support and redesign of how we deliver services.

IV. Information describing key elements of best practices in Washington State – Chelan-Douglas RSN response:

1. Describe your approach to serving complex needs of youth and how it is different than what the practice used to be and still is elsewhere in many parts of the state?

- As Chelan and Douglas are situated in rural eastern Washington, resources and programming for children and adolescents with extraordinary care needs are not always readily accessible. Residential and inpatient psychiatric care facilities are located out of the area in larger cities such as Seattle, Spokane, Yakima or the Tri-Cities. For a placement out

of the area, the family needs to travel significant distances outside the community which places excessive demands on them and often negatively impacts their ability to participate in the ongoing treatment and care of their children. We have worked to engage families whose needs have not, and in all probability, will not, be met through standard outpatient interventions. Believing placement in programs out of the area would not be conducive to the maintenance of the family structure, it was apparent that certain high need families would benefit from "Intensive Family Support Services".

- Historically, these "hard to serve" children and families were given the standard package of mental health services. When these attempts fell short, alternative placement arrangements thought to be necessary and families were separated. It is our belief and philosophies that these high need families do not always fit into the routine or categorical services generally offered by the public mental health system. We work to ensure that families are not separated, and firmly believe that children tend to fair better in their family of origin rather than in alternative placements. We believe that most acting out behavior is representative of unmet needs of a child and family and that the imperative task is to sort out and address these unmet needs. It is essential to develop and maintain close relationships with the children and families and to hear and respond to their stated needs. Subsequently, we believe that when families have an active role in developing their service packages, they will respond positively and productively in manners that allow for healthy growth and positive outcomes within the family.

- We work to employ an approach that involves not only the family but also natural supports and other allied social service agencies in a wrap-around/ child and family team model. To serve these children and families with exceptional needs, the child and family teams, in collaboration with the mental health service providers, develop individual budgets that are an integral part of the plan of care to address needs of families. As necessary Intensive Family Support Teams or staff are employed. These enhanced supports work non-traditional work schedules (evenings and week-ends) to be available when needs occur, rather than after the fact. They work intensively with families to develop behavioral interventions which focus on unique family needs and individual strengths, to promote positive change.

- Our redesign came to pass as a response to an emergent situation concerning a family whose concerns presented as so extreme that the children's providers clearly believed they were unable to meet the needs of this family. The CDRSN had set aside funds for exceptional care needs and expenses. These monies were to address the needs of individual families that were beyond that of the standard contracted package of services. All of the contracted providers were given the opportunity to develop resources necessary to work with high needs families and contract with the CDRSN to provide necessary services.

2. What did it take to get this new approach started in your community?

    - We worked to develop and maintain productive relationships with other child serving agencies. The CDRSN has met regularly with a number of children serving agencies and committees whose membership includes representatives from the majority stakeholders concerned with services to children and families. We have worked to enhance the concepts of Individualized and Tailored Care (ITC) within a context of needs driven, family focused collaborative approaches to service.

    - The CDRSN arranged for Pat Miles to provide training on ITC to the community and to offer ITC facilitator training to child and family serving professionals, consumers, and community members.

    - We were lucky to have several providers who were willing to take chances and to think beyond services as they have traditionally been approached. They worked to focus on unmet individual needs to develop interventions outside of the accepted mindset of customary service delivery and to be committed to keeping the family intact and avoiding out-of-home placements at all costs.

3. How did you get the resources to get started and the flexible funding you need?

    - Exceptional Care Funds were developed from a portion of savings from inpatient costs.

    - Exceptional Care Funds are also a line item in the annual CDRSN budget.

- The CDRSN has always embraced the concept of flexible funding to address unmet needs of children and families. This use of flexible funding engages the concept from a broader perspective attempting to consider and meet needs, rather than to have limited interventions due to categorical and restrictive funding requirements.

4. How many youth do you serve and what challenges do they face?

    - During the past year the Intensive Family Support activities have served five (5) families and ten (10) children within those families.

    - One hundred (100) per cent of the families served were at extreme risk of out-of-home placements. They also suffered from severe mental illness including significant cognitive impairments, or were violent, aggressive and impulsive, placing themselves or others at risk. These are children who had been suspended from school, had received services from or referrals to the juvenile justice system, had substance abuse concerns, and had a history of psychiatric hospitalizations.

5. How does your community feel about these kids being served in the community? How did you educate the community or change public perception about these kids?

    - In some circumstances the community feels that these hard to serve children should be placed out of the community in DCFS group homes or CLIP placements. We have worked hard to educate other allied professionals and families about concern for lack of productive outcomes associated with out-of-home/community placements. The CDRSN and the associated provider network work hard to serve on various committees throughout the community to educate and share the advantages of avoiding alternative placements and serving children and families in their home settings. The CDRSN has consumer and community representation serving on each committee related and functioning within CDRSN quality assurance activities.

6. If you were able to recommend strategies to sustain, replicate or expand, what are the key elements that you believe must be part of the approach?

- To engage these high risk children and families, it is imperative that the philosophy and basic premise of ITC and Wrap-Around be the driving force of any strategies or approach to service.

- Flexible monies are essential to address specific and individual needs of these families. Each family presents with unique challenges. Funding that is specific, or categorical with certain pre-requisites for it use, often times becomes a barrier to meaningful interventions.

- We do not perceive "intensive family support services," as a program. Each high needs family has distinct needs and these activities are meant to meet said needs. The intended outcome is to avoid the occurrence of out-of-home placements. Activities to meet these detailed needs will be funded through exceptional care funds at the CDRSN. Providers in turn receive the funding and are responsible for organizing necessary interventions to ensure productive outcomes.

7. What do you do when the parents are unable to effectively partner due to such things as substance abuse or sexually offending behavior?

    - Parents usually present with a specific set of issues and concerns that impact the well-being of the family unit. If the parents are available and able to take an active role in the development and delivery of services, they are engaged and encouraged to take an active role regardless of their issues. It is essential to ensure safety of children involved; however, if the parental rights are intact, we believe that the parents should be involved (conference phone calls would be a way to keep parents involved when safety issues or residential issues dictate that the parents should not, or could not, actually present for the team meeting process). Parents are the true experts in matters regarding their children and whenever possible need to be involved.

8. What role do the schools play?

    - Schools play an essential role in the socialization and education of each child. We work to involve the schools on each child and family teams, however, many times we are unsuccessful.

    - Many times the schools do not want to admit, or re-admit, these high needs children due to historical behavioral incidents. The child and family teams and intensive family support staff

advocate with schools for enrollment and to ensure that the child's needs are met within the school setting.

- The child and family teams work tirelessly with the schools to ensure Individual Education Plans (IEP), 504 Plans and other contingencies are addressed to best meet the needs of the child.

- We work to offer the schools support in terms of having intensive family support staff available, as necessary, to the schools when a child cannot continue in school and needs to be removed for that day.

9. What role do you need DSHS to play?

- To avail in contract to all divisions of DSHS, flexible funding that is easily accessed and is available to child and family teams. These funds would not have categorical restrictions to be used in collaboration with other social services and allied providers to meet the needs of high risk families.

- To continue to promote the philosophy and approach of ITC in services rendered to high risk families.

10. What are your outcomes for youth, family and system? Regarding the latter, do you have any cost savings?

- Regarding the five (5) families who have received Intensive Family Support Services, two (2) have required continued funding past the initial six (6) month funding request. These two funding requests averaged a 50 per cent drop for continued services into the second six (6) month funding period. High costs of front loading funds are justified by expenditures to meet immediate family needs and higher staffing requirements during the early phase of services. As families progress and their initial needs have been and continue to be addressed, staffing requirements decrease and funding costs decrease dramatically.

- Two (2) of the five (5) families served, came into services immediately after a child had discharged from inpatient psychiatric care. To this point, no child or family who has received services has required inpatient psychiatric care. One (1) child is currently on the waiting list for CLIP.

- It is the policy of the CDRSN that children are not placed in out of state psychiatric facilities.

- By the fact that there have been no out of family placements (realizing the total number of families is small), I believe we have increased the stability of placements.

- Certainly I believe that negative behaviors have decreased, issues of safety are less significant and functioning at home, in school and with peers has improved as evidenced by the ability to decrease staffing over time.

- I believe that although the start-up costs are significantly high that the record of substantial decrease of costs over time is a positive outcome.

The savings incurred by all systems (DCFS, CPS, JRA, DASA, Law Enforcement, Medical Providers, Schools, etc.) who work with these high risk families over a period of the next ten years has the potential to be astronomical. In terms reduction of human misery, the productive outcomes of these interventions prove immeasurable.

In Region 5, there are two similar cross-systems collaboration Committees: Pierce Shared Children and Kitsap Shared Resources. There is one paid facilitator serving each county. Funding for this position comes from the RSNs, Juvenile Court, and DCFS. Cost for the position is minimal when split by two or more child serving agencies.

The charge to each committee is to develop coordinated and comprehensive service options for their "deep end" children, youth and families. A collaborative approach is developed for all referred children, with a commitment by each system partner to commit resources as needed.

In Pierce County, where the committee has been active for nearly ten years, local RSN and DCFS leadership have supported agencies in the development of intensive community-based services in order to provide alternatives to institutional or residential care. Because of ongoing efforts, new and innovative service options have been available to the committee in Pierce County since the early 1990's. Pierce County's utilization of bed days in CLIP facilities was the lowest in the state during the last reported fiscal year (7/01-6/02), and has consistently remained well under state allocated bed utilization per year since 1994. (*See CLIP Day Beds Report 1994-2001*)

The FAST (Family Access to Stabilization Team) program provided by Catholic Community Services is also in Pierce County. This service was designed to quickly (within one or two hours of referral) respond to a crisis, on a 24 hour a day/seven days a week basis. From the point of initial referral, the work is done with a sense

of urgency, with the belief that the emergency that led to the referral has created a window of opportunity for change.

The FAST team works immediately with the family to create alternatives to the use of hospital, residential and foster resources by involving people who care about the child in decision making. Family members are often asked, "If your child had been injured or was seriously ill whom would you call from within your family, neighborhood or community? Let's call those people right now and get them involved in supporting you and your daughter, son, nephew or grandchild". The FAST team is available to the family, sometimes staying throughout the night and the next week to help the family to stabilize the child's behavior and develop a plan. The approach is: what would it take to make this plan work?

For youth referred who are struggling in the out-of-home care system the same sort of questions are asked, "Who loves this child? Do the child's relatives know what is happening, is there some way that they can help? Lets get them to the table and starting working on a plan." If their whereabouts are unknown, family searches are undertaken to locate them and create opportunities for them to be involved with the youth.

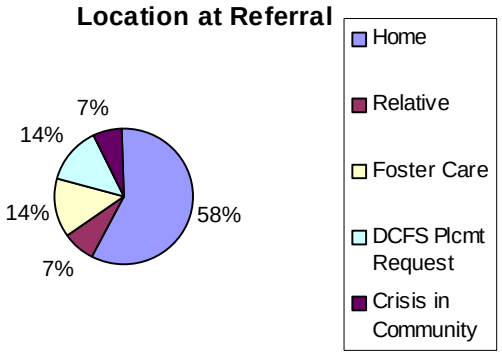
FAST has crisis respite resources when short term placement is needed, as well as staff available to stabilize and support the child in the home or foster home. All children referred receive services, no children or families are declined access. Funding for the program comes from the RSN and DCFS. They, too, are committed to finding community-based solutions for all children and families. Services are unconditional; they don't say no and they don't advocate for another system to serve the child instead. Their results for the last half of 2001 look like this:

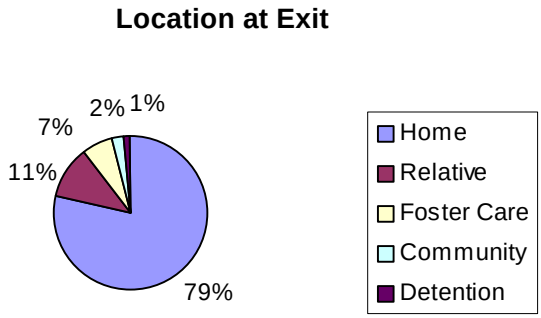
CATHOLIC COMMUNITY SERVICES
PIERCE COUNTY/ FAST

Total served in report period							
(1/1/02 - 6/30/02)							
	Unique Consumers		233				
	Total Service Episodes		239				
	Average Length of Service		59	days			
	Average Monthly Referrals		20				
Total consumers completing services during time period (1/1/02 - 6/30/02)			166				
*96 children were at imminent risk of hospitalization or residing in the hospital at the time of intake.							
**67 children were in a hospital or emergency room setting at the time of the FAST referral							

*1 child had a brief hospitalization during FAST services.							
*70 children were at risk of foster care placement or were losing their placement at the time of intake.							
*11 children remained in foster care at the completion of FAST services.							
Residential Movement for All Consumers							
At Intake		**At Exit**					
Home -		Home	90	94.7%			
95		Relative	2	2.1%			
		Foster Care	1	1.1%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	0	0.0%			
		Detention	2	2.1%			
Relative Placement -		Home	3	25.0%			
12		Relative	9	75.0%			
		Foster Care	0	0.0%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	0	0.0%			
Foster Care -		Home	15	62.5%			
24		Relative	4	16.7%			
		Foster Care	5	20.8%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	0	0.0%			
DCFS Plcmt Request.		Home	12	52.2%			
23		Relative	4	17.4%			
		Foster Care	5	21.7%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	2	8.7%			
Crisis in a Community Setting		Home	12	100.0%			

-							
		Relative	0	0.0%			
12		Foster Care	0	0.0%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	0				





Referral Source at Intake							
		RSN	96	57.8%			
		DCFS	70	42.2%			
		Total	166				
Residential Arrangement at Exit							
		Home	130	78.3%			
		Relative	19	11.4%			
		Foster Care	11	6.6%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
Referral Source at Intake							
		RSN	96	57.8%			
		DCFS	70	42.2%			
		Total	166				

Residential Arrangement at Exit							
		Home	130	78.3%			
		Relative	19	11.4%			
		Foster Care	11	6.6%			
		Hospital	0	0.0%			
		DCFS Plcmt Request	0	0.0%			
		Community	4	2.4%			
		Detention	2	1.2%			
		Total	166				
Service Disposition at Intake							
	Core Service Agency		49	29.5%			
	Other Community Agency		11	6.6%			
	CSA & Community Agency		2	1.2%			
	None		104	62.7%			
		Total	166				
Service Disposition at Exit							
	Natural Supports		73	44.0%			
	Core Service Agency		64	38.6%			
	CCS Wrap		13	7.8%			
	BRS		1	0.6%			
	TxFC		1	0.6%			
	Other		14	8.4%			
		Total	166				
School Involvement at Intake							
	Enrolled		105	63.3%			
	Not Enrolled		61	36.7%			
		Total	166	100.0%			
School Involvement at Exit							
	Enrolled		162	97.6%			
	Not Enrolled		4	2.4%			
		Total	166	100.0%			
Notes:							
***1 consumer was briefly hospitalized for acute care and released during services.*							

***6 consumers and 6 siblings were reunited with out of state extended family.*							
***6 children were referred because adoptions had disrupted.*							
***50% were returned to the adopted homes.*							
***50% were united with biological family or extended family of adoptive parents.*							

For youth with long term, multi-system involvement and complex needs, Pierce County implemented a Wraparound approach in 1990. Funded through the Pierce County RSN, Catholic Community Services currently provides Wraparound interventions to about 150 youth and families each year. In July of 2001, the Clark County RSN added the Wraparound approach (also through Catholic Community Services) to their system. Currently, about 55 youth and families per year are served.

Youth referred generally have histories of one or more psychiatric hospitalizations (64%), and are either in the process of a referral to institutional placement and/or have been unsuccessful in out-of home care. Frequently these are the youth who have exhausted all other service and placement options, including residential care, and come with high acuity and severe histories with regard to assaultive, or self-destructive behaviors, severe mental health issues, and other behavioral challenges (i.e. fire-setting, sexual offenses, suicide attempts requiring medical care, etc.). This approach is designed to serve as an alternative to more traditional or medically oriented models of care, with the intent that youth and families will achieve positive outcomes together, and utilization of more restrictive and costly resources will be decreased. In Pierce County, the use of long-term inpatient residential care has been low since 1994 (averaging 58% utilization of the number of bed nights allocated by the state). During the last fiscal year the use was only 27%, the lowest in the state in a comparison across RSNs. In Clark County, the average utilization for the three years *prior* to implementing Wraparound was 158% of the number of bed nights allocated, well over the maximum. Following the implemention of Wraparound interventions, utilization decreased significantly, from 158% to 62%. Clark County also currently has the lowest utilization in the state of children's (psychiatric) hospitalizations, with Pierce County closely following. (S*ee Section III Promising Practices and Model Programs for a description of Wraparaound*)

Catholic Community Services
Pierce County
Outcomes and Indicators
Intensive Wraparound Services
Six-Month Report
1/1/02 – 6/30/02

1. Total served biennium to date: (7/1/01 – 6/30/02) — 188

2. Total served in report period: (1/1/02 – 6/30/02) — 93

3. Total exited during report period: — 38

4. Average length of service for consumers who exited during report period: — 15 months

5. Hospitalization:

Pre-referral	64 %
During/Post	8 %

6. Population Description/Criteria for Referral:

At referral 100% were at risk of:

(1) (Repeated) psychiatric hospitalization
(2) Admission for long-term institutional placement (CLIP)
(3) Out-of-home/therapeutic foster care

7. Living Situation:

At Referral:	68%	Family
	62%	Home
	6%	Relatives
	23%	Group Care
	9%	Foster Care
At Exit:	91%	Family
	85%	Home
	6%	Relatives
	3%	Foster Care
	3%	Group Care
	3%	Adoption

8. Service Disposition/Involvement:

At Referral:	61%	Core MH Center
	3%	Community Providers
	7%	Natural Supports
	32%	Connected to DCFS
At Exit:	16%	Core MH Center (84% did not need ongoing MH services at exit)
	20%	Community providers
	91%	Natural Supports

9. School Involvement:

At Referral:	59%	Enrolled in school (FT, PT, SpEd)
	2%	Not enrolled in school
	10%	Suspended
	8%	Stopped attending
	21%	Released from institution/residential setting and not enrolled
At Exit:	100%	Enrolled in FT school
	89%	FT Regular
	3%	JRA
	8%	Alternative School

10. Children involved in significant events during report period: 2%

11. Children receiving psychiatric services at intake: Unknown
Children receiving

CCS psychiatric services during report period: 76%

12. Children with a medical home
at referral: 76%
at exit:

13. Was out-of-home or a MORE restrictive placement averted during services: 97%

Of the 38 transitioned Wrap families:

95 %	Yes
5%	No

14. Of the 38 transitioned families:

71% received financial assistance to meet basic needs for food, clothing, and medical care.

59% were assisted in accessing financial aide (i.e., TANF, food stamps, SSI, etc)

During the intervention 39% of the adults were assisted in obtaining employment.

Appendix C
Foster Parents' Rights and Responsibilities

- The RIGHT to be treated with consideration and respect by agency staff;
- The RIGHT to a supportive relationship from the agency;
- The RIGHT to receive reimbursement for the children in their care in a timely
- manner;
- The RIGHT to be trained in the role as members of a team;
- The RIGHT to give input into the decisions regarding the child in their care and to be treated as a member of the team in developing case plans for the child;
- The RIGHT to a clear explanation or description of their role as foster parents and the role of the child's family and the agency;
- The RIGHT to receive pertinent information about the children in their care;
- The RIGHT to be informed of any grievance procedures or access to any appeals process should they wish to appeal the agency's policy, regulation, or plan for a child in their care;
- The RIGHT to continue their own family patterns and traditions;
- The RIGHT to refuse to accept a child into their family if they feel they cannot meet the needs of the child or the placement will affect the well-being of the foster family;
- The RIGHT to be notified of any Court action, Administrative Review, or Foster Care Citizen Review Board Hearing concerning a child in their care. Per Washington statute; the Judge makes the decision regarding a foster parent attending a Court Hearing;
- The RIGHT to be included in the permanency consideration for the child who is in the foster family's care;
- The RIGHT & RESPONSIBILITY to advocate for children in their care;
- The RESPONSIBILITY for the day-to-day care and nurturance of the child;
- The RESPONSIBILITY for keeping the agency informed of any changes in the child's life and in the foster parent's household;
- The RESPONSIBILITY to respect a child's biological family, traditions, culture and values;
- The RESPONSIBILITY to gain further knowledge and expertise regarding the care of children by attending on-going foster parent training;
- The RESPONSIBILITY to work cooperatively with agency staff as members of the child's team; and
- The RESPONSIBILITY to ensure a child's health and safety needs are met.

This statement of Rights and Responsibilities represents a collaborative effort by foster parent work groups and the Department of Social and Health Services. This statement is based on the Child Welfare League of America's document entitled "Foster Parents' Rights and Responsibilities." Its purpose is to provide guidelines that will direct the course of relationships between foster parents and the Department of Social and Health Services toward the mutual goal of fostering safe, healthy children. This statement is not intended to create any duties that do not already exist in statute for either foster parents or on the Department. Nothing in this statement is intended to create a private right of action or claim on the part of any individual or entity. May 2001.

Appendix D
Partial List of Statutes, Case Law and Regulations

RCW 19.27.060 (State Building Code)
Snohomish County v. State, 97 Wn.2d 646, 648 P.2d 430 (1982)
AGO 1992 No. 25
RCW 70.128.175(2)
RCW 35.82.285
RCW 36.70A.200 (Growth Management Act)
RCW 71.09.020
State Environmental Policy Act (SEPA), RCW 43.21C
RCW 4.24.590
Carey v. Reeves, 56 Wn. App. 18, 22, 781 P.2d 904 (1989)
RCW 4.92.060
RCW 74.14B.080
WAC 388-25-0315
Olmstead v. L.C., 527 U.S. 581, 119 S. Ct. 2176, 144 L. Ed. 2d 540, 587 (1999)
RCW 4.24.550(1)
RCW 4.24.550(4)
RCW 13.40.215
Title IVE (42 U.S.C. § 672, et seq.)
20 U.S.C. §1400, et seq. (Individuals with Disabilities Education Act - IDEA)
RCW 71.34.080
RCW 71.34.030
RCW 71.34.052
RCW 13.32A
T.B. v. CPC Fairfax Hospital, 129 Wn.2d 439, 918 P.2d 497 (1996)
RCW 71.34.052(5), added by Chapter 296, §17, Laws of 1998
RCW 13.40.210(4)
RCW 13.34.060
Dependency of A.N., 92 Wn. App. 249, 973 P.2D 1 (1998)
RCW 13.34
42 U.S.C. § 5633 (Federal Juvenile Justice and Delinquency Prevention Act
42 U.S.C. § 5603
Placement of R.J., 102 Wn. App. 128, 5 P.3d 1284 (2000)
In re the Interests of M.G., 103 Wn. App. 111, 11 P.3d 335 (2000)
RCW 13.32A.191, et seq.

Appendix E
Sample Placement History for a 'Hard to Place' Youth

Ethnicity: Hispanic	Current Age: 17	Age at 1st Placement: 10	Gender: M	Legal Status: Dependent Parent's rights terminated.

Diagnoses/Issues: Axis I-1. Intermittent explosive disorder, 2-Oppositional defiant disorder; 995.5-History of Childhood Sexual Abuse/Neglect; Axis II-moderate mental retardation; Axis III 1-Seizure disorder with no recent seizure episode, Axis IV-moderate psychosocial stressors; Axis V-Global Assessment of Functioning score of 50. Fetish with women's undergarments

Education Information: Special Education. Has a long history of scholastic performance problems.

Case Summary/Family Background: This child and a sibling have a similar history of behavioral problems, are 1 year apart in age and have the same parents. Both lived with their parents except for one year in 1985 when they lived with their father. The mother lived with a previous husband, but visited frequently. In 1985 the family reunited. During the children's attendance at an elementary school in 1994 both were reported to display inappropriate sexual behavior, various forms of verbal and physical aggressive behaviors. The therapist attempted to have the parents provide behavioral data on the children in the home setting but they did not comply. The children's teacher did keep a log and noted incidences of masturbation, swearing at a teacher, threatening staff, making obscene gestures, and choking another student. The therapist continued to work with the parents to improve the behavior patterns of the children within the home environment.

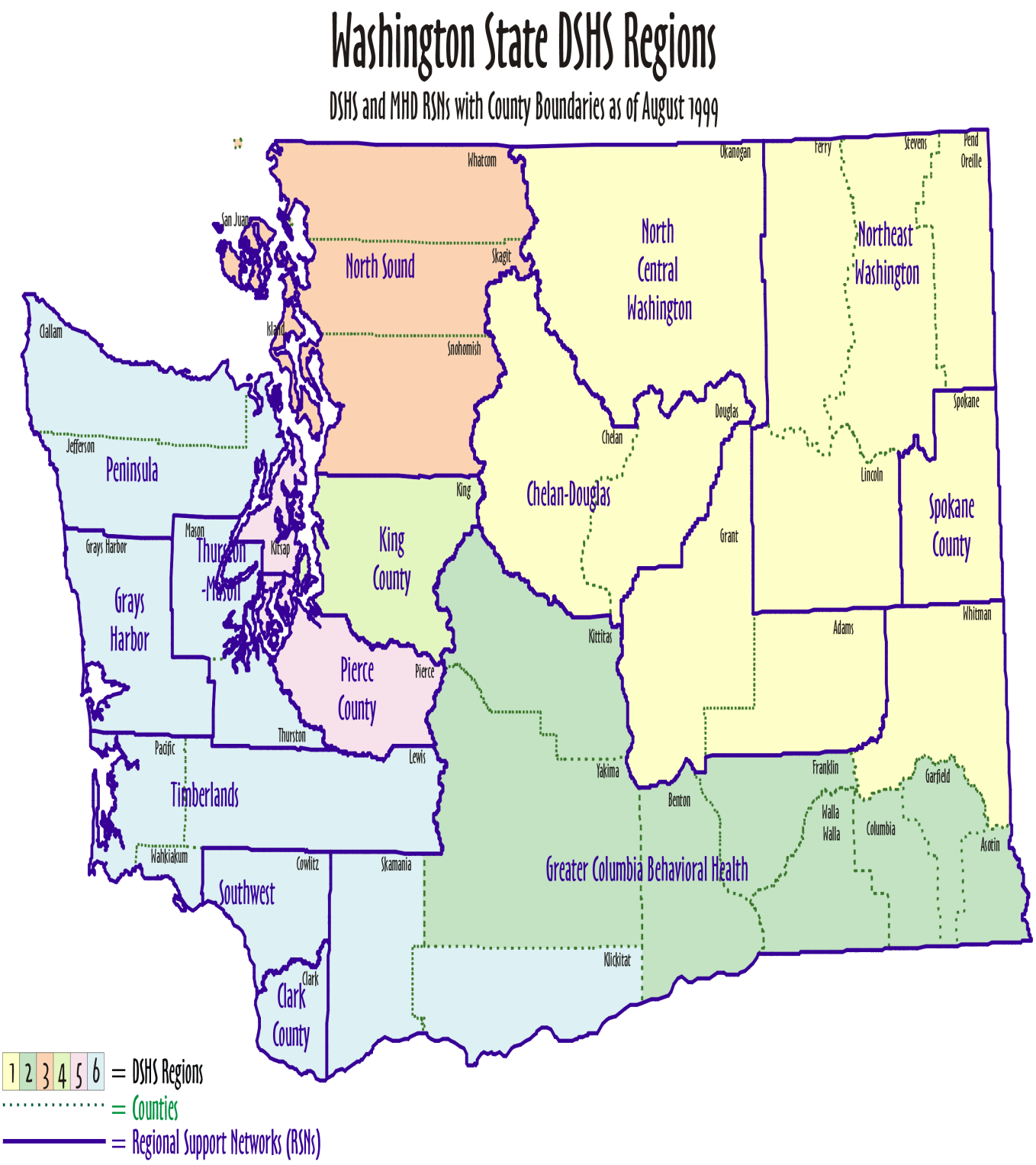
Placement History:

1989:	Short term foster care placement as a result of CPS issue; children were returned home and case was closed
10/94–11/94:	Foster Home – Sunnyside – caregiver request to move; can't handle boys
11/94:	One day CRC placement – Yakima – Behavior out of control
11/94:	Two week placement while arrangements made for Children's Hospitalization Alternative Program (CHAP)
11/94–6/96:	(CHAP) foster home – Yakima – completed CHAP services
6/96–11/00:	Foster Home – Wapato – guardianship established; guardian asked for placement and discontinued contact when behavior became too hard and frightening to manage
11/00–12/00:	13 placements lasting 1 day to 1 week; included BRS foster homes, detention, and secure CRC placements
12/00–2/01:	Respite – Yakima Valley School (DDD institution serving adult DDD clients)
2/01–9/01:	BRS foster home – blew out of home due to behavior
4/01:	psychiatric hospitalization
9/01–10/01:	Temporary Foster Home while new BRS placement is located
10/01–present:	BRS placement in a staffed residential setting (small group care environment of up to 6 youth)

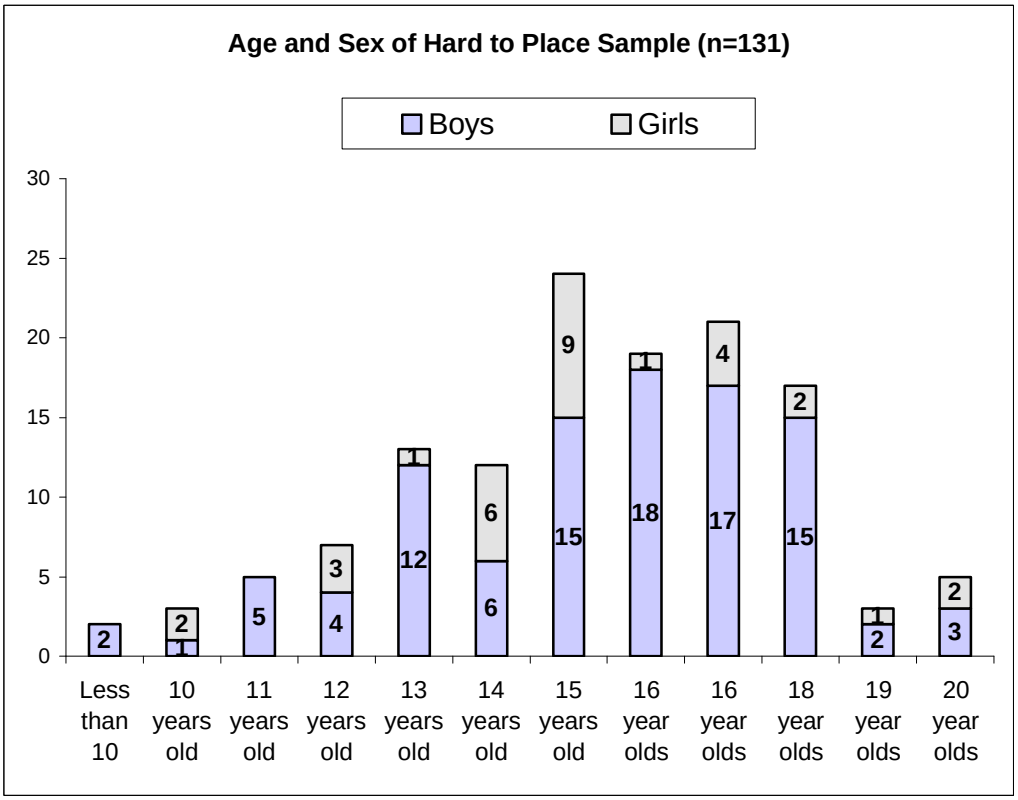
Child's Situation: Current Location: BRS Therapeutic Foster Home
In 1994, when this child was 10 yrs. of age, the children were removed from the home due to long-standing neglect and sexual abuse. For a period of time both children were in the same foster home but in 1998 the brother was removed due to behavior. Around March 2000, the foster mother had this child evaluated because of two incidents of inappropriate touching of a young boy in a school bus and a female peer in the hallway at school. Psychiatrists have evaluated him since the age of 7 when he was first diagnosed with slight retardation. It was suspected that he was exposed to alcohol in utero. In 1998, it was recommended that he be removed from the foster home and in Oct. 2000, the new foster mother requested that he be moved because of job hours and stress. Nov. 2000, his guardian signed VPA and severed ties. 11/24/00, this child threatened to leave new foster home, and SW, police and EPIC became involved. IL considered. December 2000, staffing done to determine placement with Service Alternatives to stabilize meds. & behaviors. Plan was for long term foster care and focus on IL skills. Historically, he has used the service of the Yakima Valley Farm Workers Clinic extensively for medical and psychiatric services. He is usually on 3-4 meds. He was admitted to Sacred Heart in Spokane to the Psychiatric Center for Children and Adolescents because of homicidal threats to foster mother and brother. A MRI and other diagnostic tests were done. He remained there 4/13-4/27/01, with a diagnosis of psychosis with increased aggression.

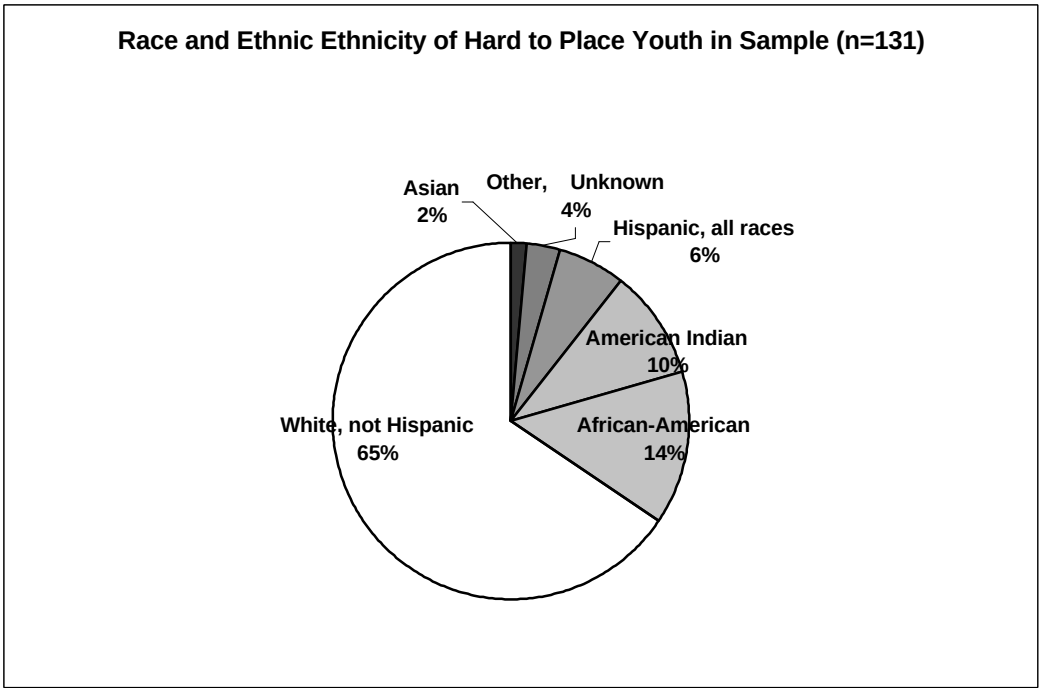
Medication history includes Depakote, Zyprexa, Paxil, and Trazodone.

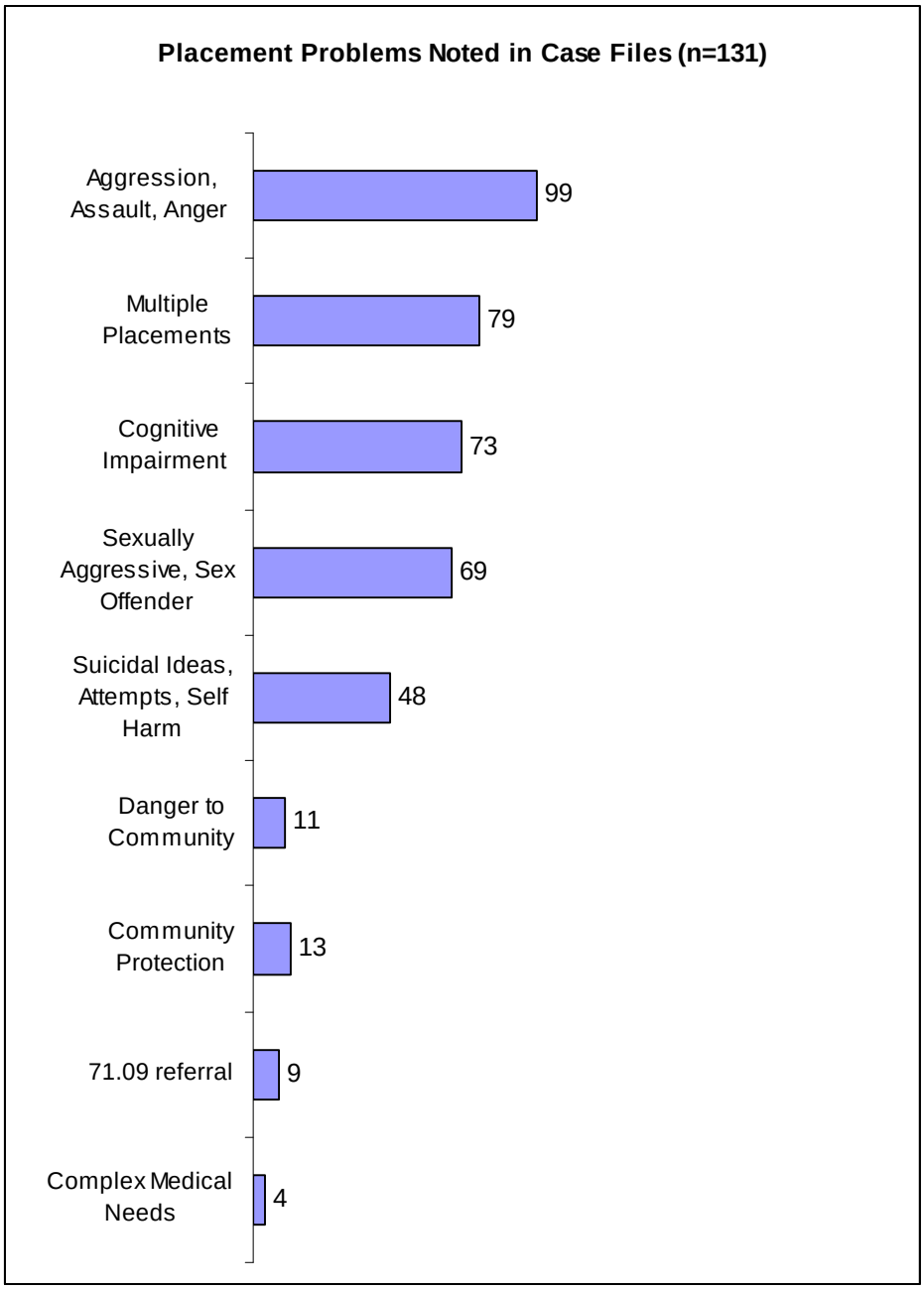
Appendix F
Map of DSHS and RSN Regions

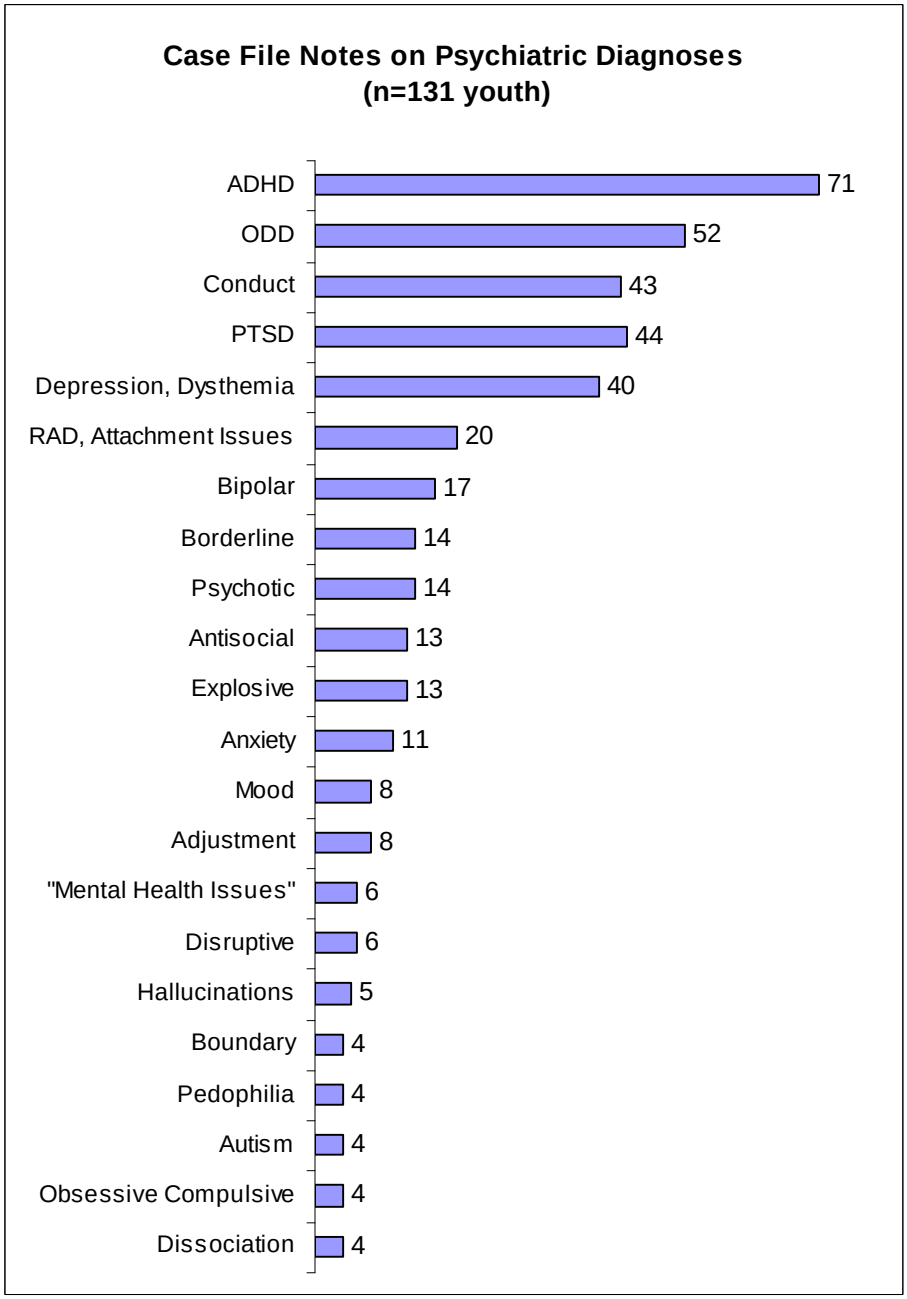


Appendix G
Additional Demographic Information



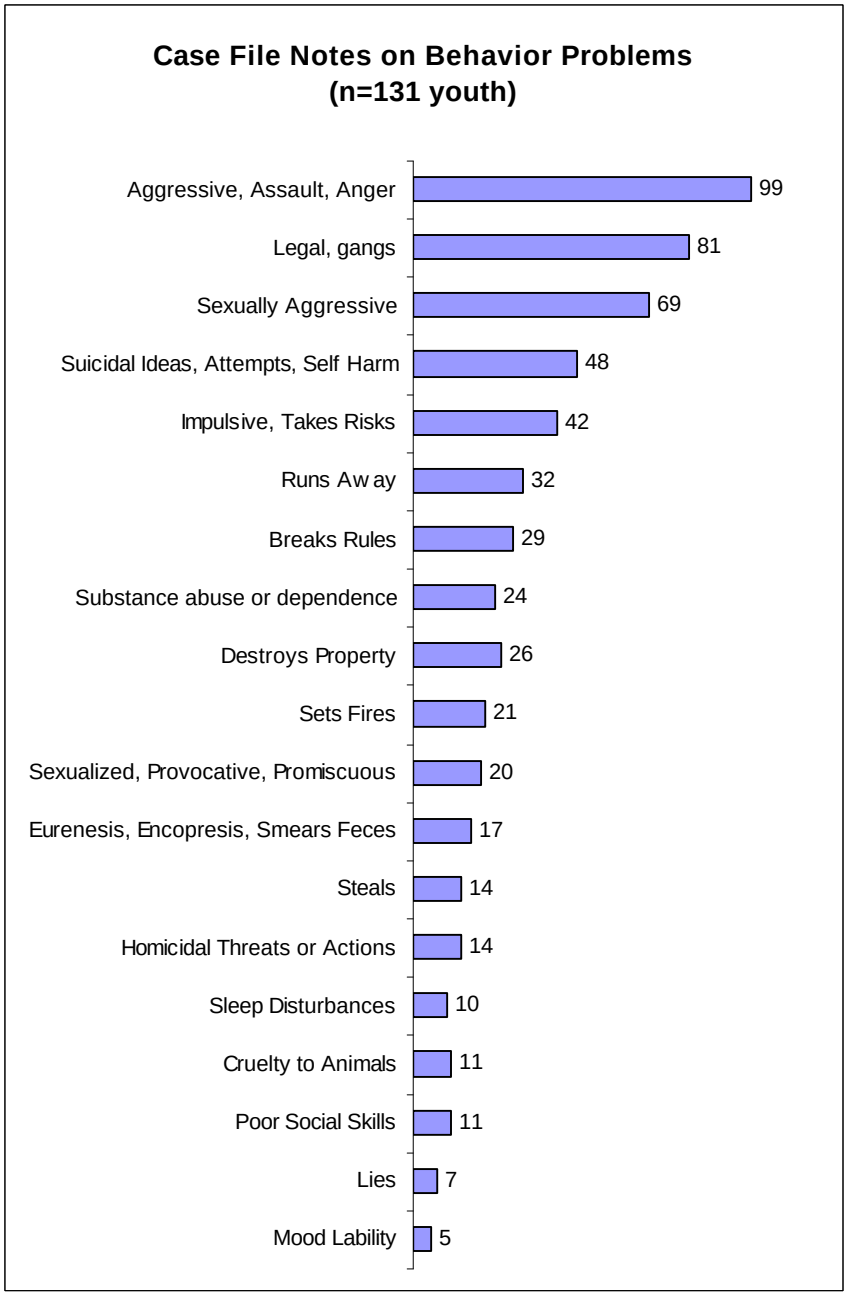



Placement Problems Noted in Case Files (n=131)
Aggression, Assault, Anger
99
Multiple Placements
79
Cognitive Impairment
73
Sexually Aggressive, Sex Offender
69
Suicidal Ideas, Attempts, Self Harm
48
Danger to Community
11
Community Protection
13
71.09 referral
9
Complex Medical Needs
4



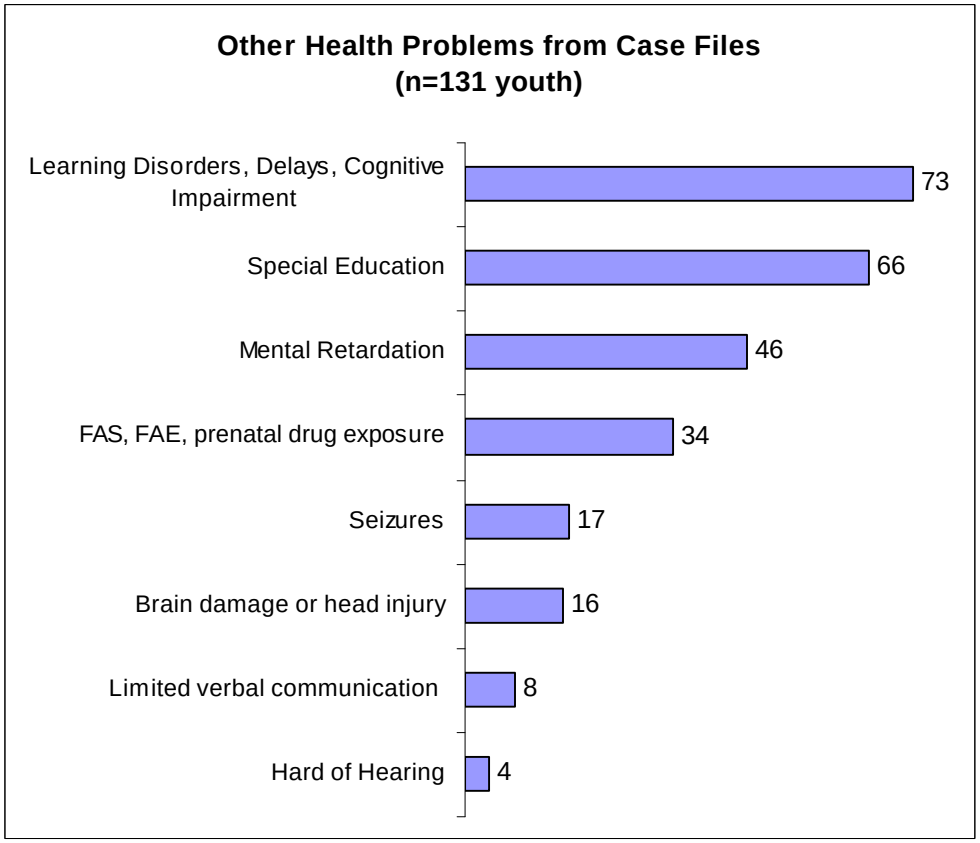
Additional diagnoses in the case files for these youth included Asberger's syndrome and Organic Personality Disorder (3 youth each); Personality Disorder, Tourette's (2 youth each) and one youth with each of the following: Paraphilia, Schizotypal, Narcissism, Histrionic personality, Anorexia, Pica, Klinefelter's syndrome, Fetishism, Prader-Willi, Coprophillia, Phonologic Disorder.

The completeness of the diagnostic record in this sample depended partly on how much material from the case files was moved forward from the field to headquarters in the case abstracts. It also depends on which program presented the case, because each program went only to its own case records.



Additional behavior problems included excessive screaming (2 youth) and exhibiting (2 youth). One youth hoards food and another masturbates compulsively.

The completeness of the behavioral problem record in this sample depended partly on how much material from the case files was moved forward from the field to headquarters in the case abstracts. It also depends on which program presented the case, because each program went only to its own case records. Some programs presented only the behavior most problematic in placing the child, while others listed all the problem behaviors the children exhibit.



A wide range of other health conditions occurred in a few of these youth. The following diagnoses were found in two youth: encephalophy, blindness, anemia, G-tube, obesity, poor coordination or fine motor problems, chronic ear infections, post natal physical trauma. The following diagnoses were listed for only one child in the sample: cerebral palsy, reactive airway disease, tic disorder, withdrawal dyskenesia, migraines, prenatal malnutrition, hydrocephalacy, XYY chromosome abnormality, scoliosis, osteoporosis, hypotomia, club feet, thyroid problems, final stage renal failure, and diabetes.

The completeness of the behavioral problem record in this sample depended partly on how much material from the case files was moved forward from the field to headquarters in the case abstracts.

Appendix H
Legal Authority for 'Hard to Place' Youth by Administration

	Child Welfare	Juvenile Rehabilitation	Developmental Disabilities - Residential	Mental Health - Commitment
Upper Age Limit	18, voluntary services in limited circumstances to 21	Can retain to 21 depending on sentence and parole requirements	None	None; children under 18 cannot be placed in an adult inpatient facility.
Basis for DSHS custody/ control	Child abandoned, abused or neglected (RCW 26.44.050; RCW 13.34.030 et. seq)	Youth adjudicated guilty of an offense and sentenced to confinement in excess of 30 days (RCW 13.40.185)	A developmental disability and need residential placement, and (1) a voluntary placement agreement; or (2) placement in a Residential Habilitation Center (RHC). Children under 13 can't be placed in an RHC.	(1) Voluntary under 13-by parent; (2) Voluntary 13 and over – child can self-admit, subject to parents' request for hearing, medical necessity determination and space' (3) Involuntary 13 and over – diagnosis of mental disorder causing individual to be gravely disabled or danger to self or others; (4) Statute provides authority for parent to admit child 13 and over without child's consent. Must be medically necessary; (5) Forensic — accused of crime and determined incompetent to

	Child Welfare	Juvenile Rehabilitation	Developmental Disabilities - Residential	Mental Health - Commitment
				stand trial or not guilty by reason of insanity.
Duration	Until child (1) returned to parents; (2) parental rights terminated and child is adopted; or (3) child turns 18 (up to 21 if in school).	Until (1) end of determinate sentence imposed by juvenile court plus any parole period determined by JRA; or (2)youth turns 21, whichever happens first	Voluntary placements are indefinite and can be terminated at any time; court review required within 180 days to determine that placement is in the best interest of the child No time limit for RHC admission	Voluntary placement terminable at any time; Child 13 and over admitted by parent may not be discharged solely on the basis of their request to leave. Child may petition superior court for release. Involuntary commitments subject to periodic court review
Decision Makers	DSHS has "custody, care and control"; juvenile court makes dispositional orders, and conducts six month reviews; finalizes terminations and adoptions	Juvenile court determines range of sentence term; During confinement, JRA makes supervision, custody, release date and treatment decisions JRA determines post-release parole, but has limited supervision	Both parents and DSHS must agree to voluntary placement agreement Once placed in Residential Habilitation Center (RHC) DSHS has "custody and control of residents . . . and their treatment" (RCW 71A.20.050(2))	Initial 3 day involuntary commitment by local mental health professional; subsequent commitment decisions and review by Superior Court; Once committed, DSHS has broad discretion as to treatment and placement, subject to

	Child Welfare	Juvenile Rehabilitation	Developmental Disabilities - Residential	Mental Health - Commitment
		during parole		constitutional and statutory limitations. Counties (through the Regional Support Networks), parents and providers participate in the placement decisions; a statutorily mandated committee makes final placement decisions for both voluntary and involuntary patients. For voluntary patients, treatment and discharge decisions are made by the parent and provider.
Authority to restrict physical movement to a particular location	Arguably same as parents; DSHS can work with law enforcement to facilitate 5 day secure Crisis Residential Centers (RCW 13.32A.130). No statutory authority to place	During confinement, JRA has complete placement discretion, subject to constitutional or statutory limitations During parole, no placement	Statutory authority for 48 hour hold on RHC residents who indicate desire to leave if doing so would place them in immediate risk of harm. (RCW 71A.20.140).	Commitment can be inpatient or for less restrictive outpatient treatment. Once lawfully committed, broad authority subject to statutory or constitutional limitation.

	Child Welfare	Juvenile Rehabilitation	Developmental Disabilities - Residential	Mental Health - Commitment
	a child in a secure treatment facility through dependency statutes.	authority and limited supervision		For child 13 and over admitted by parent, authority to restrict as agreed by parent and provider. Voluntary patient may give notice to leave at any time.
Funding sources	Title IVE (federal) State general fund Reimbursement from SSA/SSI (Keffeler) Most children eligible for Medicaid	State funds while confined, Not eligible for Medicaid during confinement except in mental health treatment facility; Parents required to pay portion of cost of confine-ment per RCW 13.40.220; May be Medicaid eligible on parole	State and Medicaid funds	Private insurance, and Medicaid funds
What causes DSHS to lose juris-diction	Dismissal of juvenile court dependency petition, based on (1) return to parents; (2) adoption; or (3) child turns 18	(1) Completion of sentence and any parole obligation; or (2) Turns 21.	Parent or DSHS terminate placement or parent removes child from RHC	Determination that child no longer meets civil commitment standards Termination of voluntary admission Admission of child 13 and over by parent is terminated by parent, provider, or court.
What	On request of	Confinement to	None for	Authority

	Child Welfare	Juvenile Rehabilitation	Developmental Disabilities - Residential	Mental Health - Commitment
authority does DSHS have after child turns 18	child, can provide continued foster care to dependent children who are in school until 21; limited funding for living assistance between 18 and 21	complete sentence determined by court up to age 21; JRA has discretion to place on parole up to age 21; voluntary transi-tion planning services at release; no post-parole authority	Voluntary Placement Agreements. DSHS continues to have custody and control of treatment for RHC residents	continues into adulthood, assuming individual's mental condition warrants it. Placement changes with age.
What is the status of the child after age 18?	After age 18, DSHS has no authority to take custody under child protection statutes	For charging as a juvenile, maximum age is 18. Maximum confinement age for those adjudicated as a juvenile is 21	No voluntary placement agreement after age 18; for RHC placement, parents only authority is to consent to treatment (RCW 7.70.065)	Cannot be committed involuntarily prior to age 13; commitment standards post 13 same as for adults

This information was prepared by several Assistant Attorneys General from the Social and Health Services Division of the Attorney General's Office. It is intended to provide an overview of Washington state law as it applies to DSHS authority with respect to children, and does not purport to be either a complete statement of the law or an opinion of the Attorney General's Office.